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EXHIBITS

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CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, _____, am signing this form for
(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

(FULL PRINTED NAME OF CLIENT)

(CLIENT'S ADDRESS)

(CLIENT'S BIRTH DATE)

(CLIENT'S SSN - OPTIONAL)

My relationship to the client is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian
☐ Other Legally Authorized Representative

I want the following confidential information about the client (*except drug or alcohol abuse diagnoses or treatment information*) to be exchanged:

| Yes | No | Yes | No | Yes | No |
|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Assessment Information | | Medical Diagnosis | | Educational Records | |
| Financial Information | | Mental Health Diagnosis | | Psychiatric Records | |
| Benefits /Services Needed | | Medical Records | | Criminal Justice Records | |
| Planned, and/or Received | | Psychological Records | | Employment Records | |

Other Information (write in): _____

I want: _____

(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

And the following other agencies to be able to exchange this information:

Are More Agencies Listed on Back? YES ☐ NO ☐

I want this information to be exchanged **ONLY** for the following purpose(s):

☐ Service Coordination and Treatment Planning ☐ Eligibility Determination

Other (write in): _____

I want information to be shared: (check all that apply)

☐ Written Information ☐ In Meetings or By Phone ☐ Computerized Data

I want to share additional information received after this consent is signed: ☐ YES ☐ NO

This consent is good until: _____

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn.

I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information.

I want all the agencies to accept a copy of this form as a valid consent to share information.

If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

Signature(s): _____ Date: _____
(CONSENTING PERSON OR PERSONS)

Person Explaining Form: _____
(Name) (Title) (Phone Number)

Witness (If Required): _____
(Signature) (Address) (Phone Number)

Instructions for Completing MR Community Medicaid Waiver Level of Functioning Survey

For determining level of care eligibility for Mental Retardation Community Waiver services, consider the individual's functioning in community environments. Complete the attached survey presuming the needed services and supports are not in place for the individual. Please note that, for items in "Health Status" section, needed care or supervision may be provided by caregivers other than a licensed nurse.

DEFINITIONS:

"No Assistance" means no help is needed.

"Prompting/Structuring" means prior to the functioning, some verbal direction and/or some rearrangement of the environment is needed.

"Supervision" means that a helper must be present during the functioning and provide only verbal direction, gestural prompts, and/or guidance.

"Some Direct Assistance" means that a helper must be present and provide some physical guidance/support (with or without verbal direction).

"Total Care" means that a helper must perform all or nearly all of the functions.

"Rarely" means that the behavior occurs quarterly or less.

"Sometimes" means that a behavior occurs once a month or less.

"Often" means that a behavior occurs 2-3 times a month.

"Regularly" means that a behavior occurs weekly or more.

**MR COMMUNITY MEDICAID WAIVER
LEVEL OF FUNCTIONING SURVEY
SUMMARY SHEET**

Consumer's Name: _____

NOTE: The individual must meet the indicated dependency level in 2 or more of the following categories to justify need for services in a Medicaid-certified facility for persons with mental retardation or to meet level of care eligibility requirement for the Mental Retardation Community Waiver.

| | | | | | | |
|-------------|---------|-------------|---------|-------------|---------|---|
| Date: _____ | | Date: _____ | | Date: _____ | | |
| MET | NOT MET | MET | NOT MET | MET | NOT MET | See qualifying option in each category below: |
| | | | | | | Category 1: Health Status Two or more questions answered with a 4 or Question "j" answered yes. |
| | | | | | | Category 2: Communication Three or more questions answered with a 3 or 4 |
| | | | | | | Category 3: Task Learning Skills Three or more questions answered with a 3 or 4 |
| | | | | | | Category 4: Personal/Self Care Question "a" answered with a 4 or 5 or Question "b" answered with a 4 or 5 or Question "c" and "d" answered with a 4 or 5 |
| | | | | | | Category 5: Mobility Any one question answered with 4 or 5 |
| | | | | | | Category 6: Behavior Any one question answered with a 3 or 4 |
| | | | | | | Category 7: Community Living Skills Any two of questions "b", "e", or "g" answered with a 4 or 5 or Three or more questions answered with a 4 or 5 |
| | | | | | | |

Date: _____ Evaluator's Signature: _____
Title/Affiliation: _____

Date: _____ Evaluator's Signature: _____
Title/Affiliation: _____

Date: _____ Evaluator's Signature: _____
Title/Affiliation: _____

Consumer's Name: _____

LEVEL OF FUNCTIONING SURVEY

1. HEALTH STATUS

How often is nursing care or nursing supervision by a licensed nurse required for the following?

(See instructions as it may also be provided by caregivers.)

Please put appropriate number in the box under year of assessment.

(Key: 1= Rarely, 2=Sometimes, 3=Often, and 4=Regularly)

| | Date: | Date: | Date: |
|---|-------|-------|-------|
| a.) Medication administration and/or evaluation for effectiveness of a medication regimen | | | |
| b.) Direct services: i.e., care for lesions, dressings, treatments, (other than shampoos, foot powder, etc.) | | | |
| c.) Seizure Control | | | |
| d.) Teaching diagnosed disease control and care, including diabetes | | | |
| e.) Management of care of diagnosed circulatory or respiratory problems | | | |
| f.) Motor disabilities which interfere with all activities of Daily Living - Bathing, Dressing, Mobility, Toileting, etc. | | | |
| g.) Observation for choking/aspiration while eating, drinking | | | |
| h.) Supervision of use of adaptive equipment, i.e., special spoon, braces, etc. | | | |
| i.) Observation for nutritional problems (i.e., undernourishment, swallowing difficulties, obesity) | | | |
| j.) Is age 55 or older, has a diagnosis of a chronic disease and has been in an institution 20 years or more | | | |

Notes/Comments:

Consumer's Name: _____

2. COMMUNICATION

How often does this person...

Please put appropriate number in the box under the year of assessment.

(Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

| | | | |
|--|-------|-------|-------|
| <input type="checkbox"/> Verbal | Date: | Date: | Date: |
| <input type="checkbox"/> Non-Verbal | | | |
| a.) Indicate wants by pointing, vocal noises, or signs? | | | |
| b.) Use simple words, phrases, short sentences? | | | |
| c.) Ask for at least 10 things using appropriate names? | | | |
| d.) Understand simple words, phrases or instructions containing prepositions: i.e., "on", "in", "behind" ? | | | |
| e.) Speak in an easily understood manner? | | | |
| f.) Identify self, place or residence, and significant others? | | | |

Notes/Comments:

Consumer's Name: _____

3. TASK LEARNING SKILLS

How often does this person perform the following activities?

Please put the appropriate number in the box under the year of assessment.

(Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

| | Date: | Date: | Date: |
|---|-------|-------|-------|
| a.) Pay attention to purposeful activities for 5 minutes? | | | |
| b.) Stay with a 3-step task for more than 15 minutes? | | | |
| c.) Tell time to the hour and understand time intervals? | | | |
| d.) Count more than 10 objects? | | | |
| e.) Do simple addition, subtraction? | | | |
| f.) Write or print 10 words? | | | |
| g.) Discriminate shapes, sizes or colors? | | | |
| h.) Name people or objects when describing pictures? | | | |
| i.) Discriminate between "one", "many", "lot"? | | | |

Notes/Comments:

Consumer's Name: _____

4. PERSONAL/SELF-CARE

With what type of assistance can this person currently...

Please put appropriate number in the box under year of assessment

(Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

| | Date: | Date: | Date: |
|--|-------|-------|-------|
| a.) Perform toileting functions i.e., maintain bladder and bowel continence, clean self, etc.? | | | |
| b.) Perform eating/feeding functions: i.e., drink liquids and eat with spoon or fork, etc.? | | | |
| c.) Perform bathing function: i.e., bathe, run bath, dry self, etc.? | | | |
| d.) Dress self completely, i.e., including fastening and putting on clothes? | | | |

Notes/Comments:

Consumer's Name: _____

5. MOBILITY

With what type of assistance can this person currently...

Please put appropriate number in the box under the year of assessment.

(Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

| | | | |
|--|-------|-------|-------|
| <input type="checkbox"/> Ambulatory <input type="checkbox"/> Non-Ambulatory | Date: | Date: | Date: |
| a.) Move (walking, wheeling) around environment? | | | |
| b.) Rise from lying down to sitting positions, sit without support? | | | |
| c.) Turn and position in bed, roll over? | | | |

Notes/Comments:

Consumer's Name: _____

6. BEHAVIOR

How often does this person...

Please put appropriate number in the box under the year of assessment.

(Key: 1=Rarely, 2=Sometimes, 3=Often, 4=Regularly)

| | Date: | Date: | Date: |
|--|-------|-------|-------|
| a.) Engage in self-destructive behavior? | | | |
| b.) Threaten or do physical violence to others? | | | |
| c.) Throw things or damage property, have temper outbursts? | | | |
| d.) Respond to others in a socially unacceptable manner—(without undue anger, frustration or hostility)? | | | |

Notes/Comments:

Consumer's Name: _____

7. COMMUNITY LIVING SKILLS

With what type of assistance would this person currently be able to...

Please put appropriate number in the box under the year of assessment.

(Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

| | Date: | Date: | Date: |
|--|-------|-------|-------|
| a.) Prepare simple foods requiring no mixing or cooking? | | | |
| b.) Take care of personal belongings, room (excluding vacuuming, ironing, clothes washing/drying, wet mopping)? | | | |
| c.) Add coins of various denominations up to one dollar? | | | |
| d.) Use telephone to call home, doctor, fire, police? | | | |
| e.) Recognize survival signs/words: i.e., stop, go, traffic lights, police, men, women, restrooms, danger, etc.? | | | |
| f.) Refrain from exhibiting unacceptable sexual behavior in public? | | | |
| g.) Go around cottage, ward, building, without running away, wandering off, or becoming lost? | | | |
| h.) Make minor purchases, i.e., candy, soft drinks, etc.? | | | |

Notes/Comments:

DOCUMENTATION OF RECIPIENT CHOICE
BETWEEN INSTITUTIONAL CARE OR HOME AND COMMUNITY-BASED SERVICES

Recipient Name: _____

The following has been presented and discussed with the recipient and, if applicable, the parent, legal guardian or authorized representative:

- The findings and results of the recipient's evaluations and stated needs;
- All feasible alternatives/available services for which he or she is eligible under the Mental Retardation Community Waiver; Name the alternative/available waiver services discussed: _____

- Plans for providing services to meet the recipient's needs;
- A choice between institutional care and Mental Retardation Community Waiver services. Name the institutional care discussed: _____

- Information that the recipient may be placed on the Waiting List for both ICF-MR and MR Waiver Services;
- Information that the recipient may be placed on the MR Waiver Waiting List and receive services in an ICF-MR at the same time;
 - The recipient's right to a fair hearing and the appeal process.

The recipient and, if applicable, the parent, legal guardian or authorized representative, has:

_____ selected Mental Retardation Community Waiver services (may require placement on the waiting list);

_____ selected ICF-MR services (may require placement on the waiting list); OR

_____ selected to be served in an ICF-MR or placed on an ICF-MR waiting list and be placed on the MR Waiver Waiting List at the same time.

Signature of Recipient

Date

Signature of Parent, Legal Guardian, Authorized
Representative (underline applicable designation)

Date

Signature of Case Manager

Date

Department of Mental Health, Mental Retardation and Substance Abuse Services

MR WAIVER ENROLLMENT REQUEST

| | | | |
|--|--|--|---|
| Coordinating CSB: | <input style="width:95%;" type="text"/> | Provider #: | <input style="width:95%;" type="text"/> |
| Individual's Name: | <input style="width:20%;" type="text"/> | <input style="width:20%;" type="text"/> | <input style="width:10%;" type="text"/> |
| | LAST | FIRST | M.I. |
| | | | Male <input type="checkbox"/> Female <input type="checkbox"/> |
| Medicaid Number: | Birthdate: (mo/dy/year) | Social Security No.: | Date of Application to CSB: |
| <input style="width:100%;" type="text"/> | <input style="width:100%;" type="text"/> | <input style="width:100%;" type="text"/> | <input style="width:100%;" type="text"/> |

| | | | | | | | | | | |
|---|---|--|---|--------------------------------------|---|--------------------------------------|--|---|--|--|
| Current Living Arrangement <input type="checkbox"/> Resident of State Training Center <input type="checkbox"/> Applicant to state or community ICF/MR <input type="checkbox"/> Resident of state MH hospital <input type="checkbox"/> Resident of community ICF/MR <input type="checkbox"/> Living in community, at risk of institutionalization <input type="checkbox"/> Resident of nursing facility | Race (for data purposes only) <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other (specify): _____ | ICF/MR Level of Functioning <i>Check the following categories in which dependency level is met (must be met in 2 or more)</i> <table style="width:100%;"> <tr> <td><input type="checkbox"/> 1. Health Status</td> <td><input type="checkbox"/> 5. Mobility</td> </tr> <tr> <td><input type="checkbox"/> 2. Communication</td> <td><input type="checkbox"/> 6. Behavior</td> </tr> <tr> <td><input type="checkbox"/> 3. Task Learning skills</td> <td><input type="checkbox"/> 7. Community Living Skills</td> </tr> <tr> <td><input type="checkbox"/> 4. Personal/Self Care</td> <td></td> </tr> </table> | <input type="checkbox"/> 1. Health Status | <input type="checkbox"/> 5. Mobility | <input type="checkbox"/> 2. Communication | <input type="checkbox"/> 6. Behavior | <input type="checkbox"/> 3. Task Learning skills | <input type="checkbox"/> 7. Community Living Skills | <input type="checkbox"/> 4. Personal/Self Care | |
| <input type="checkbox"/> 1. Health Status | <input type="checkbox"/> 5. Mobility | | | | | | | | | |
| <input type="checkbox"/> 2. Communication | <input type="checkbox"/> 6. Behavior | | | | | | | | | |
| <input type="checkbox"/> 3. Task Learning skills | <input type="checkbox"/> 7. Community Living Skills | | | | | | | | | |
| <input type="checkbox"/> 4. Personal/Self Care | | | | | | | | | | |
| <input style="width:100px;" type="text"/> Date completed | | | | | | | | | | |

Diagnostic Eligibility
 Name of evaluator: _____
 License/Credentials/Title: _____

 Date psychological evaluation completed, age 6 & over
☐ Confirms diagnosis of mental retardation, as defined by AAMR; documentation in record addresses:
 ☐ Intellectual functioning
 ☐ Adaptive functioning
 ☐ Age of onset

 Date standardized developmental evaluation completed, under age 6 yrs.
☐ Confirms "developmental risk"

Comments

The individual or parent/legal guardian has been given the choice between institutional care and MR Community Waiver services, has signed the "Documentation of Recipient Choice" form, and has selected MR Waiver. With the submission of this form, I certify that the above information is accurate, complete and maintained in the individual's record.

| | | |
|--|------------|----------------------------|
| Signature of CSB Representative/Case Manager _____ | Date _____ | Phone _____ |
| Signature of MR Director _____ | Date _____ | Requested Start Date _____ |

This form must be submitted with the Recipient Choice Form (unless already submitted for Waiting List).

This individual has been screened and approved to receive MR Waiver services and is waiting to receive Medicaid eligibility determination.

| | | |
|---------------------------------------|------------|-------------|
| Signature of OMR Representative _____ | Date _____ | Phone _____ |
|---------------------------------------|------------|-------------|

Instructions for the Completion of the MR Waiver Enrollment Request Form (DMAS-437)

If these are handwritten, please print clearly.

1. In the upper left hand corner, enter a check mark if this is an *emergency* request.
2. Identifying Information
 - ***Coordinating CSB:*** Enter the name of the CSB providing (or contracting for) Case Management Services.
 - ***Provider Number:*** Enter the provider number of the CSB named in the previous block.
 - ***Consumer Name:*** Enter the consumer's last name, first name and middle initial in the appropriate blocks.
 - ***Male/Female:*** Check the applicable box to indicate the consumer's gender.
 - ***Medicaid Number:*** Enter the consumer's 12 digit number.
 - ***Birthdate:*** Enter the consumer's date of birth in the order "month-day-year."
 - ***Social Security Number:*** Enter the consumer's 9 digit number.
 - ***Date of Application to CSB:*** Enter the date the individual (or representative on behalf of the individual) first contacted the CSB, requesting services that may be provided under the MR Waiver.
1. ***Current Living Arrangement***

Check the appropriate box that describes the consumer's living arrangement at the time of this request (i.e., prior to MR Waiver services).
2. ***Race*** (Used for data purposes only.)

Check the appropriate box that most accurately describes the consumer's race.
3. Diagnostic Eligibility
 - ***Name of evaluator:*** Enter the name of the individual who tested and summarized the consumer's psychological or developmental evaluation.

- ***License/Credentials/Title:*** Enter the evaluator's license, credentials or title as it appears on the psychological or developmental evaluation.
- ***Date of psychological evaluation:*** If the consumer is 6 years of age or older, enter the date of the most recent psychological.
- ***Confirms diagnosis of mental retardation:*** Check that this most recent psychological confirms a diagnosis of mental retardation. Check also that this psychological addresses the three required components. Adaptive functioning and age of onset may also be checked if these are addressed in other documents contained in the consumer's record, but should be easily accessible for review in the record. All of these 3 elements must be **checked for approval.**
- ***Date . . . developmental evaluation completed:*** If the consumer is under 6 years of age, enter the date of the most recent developmental evaluation confirming developmental risk.
- ***Confirms developmental risk*** (if the consumer is under the age of 6): Check that the most recent developmental evaluation confirms a diagnosis of developmental risk (as defined in Chapter VI).

1. ***Comments***

Space is provided for any necessary explanations or other comments that will assist DMHMRSAS in determining eligibility for enrollment into the MR Waiver. ***If this is an emergency request, "Emergency" must be entered in this section and a narrative attached (as described in the manual: Chapter IV , page 50).***

2. ***Signatures***

The case manager or other responsible CSB representative must assure that the requirements listed are met by signing and dating the form, including the phone number of the signer as well.

The CSB MR Director must indicate agreement with this request, sign and date and include the requested start date for services to begin.

In order for the Enrollment Request to be considered, the complete LOF, Recipient Choice Form and *abbreviated* Plan of Care Summary form (see instructions) must accompany this form.

3. An OMR representative must approve, sign and date this request and include the approved start date. For individuals with pending Medicaid eligibility, this form must be submitted with the DMAS-122 to the local DSS for determining eligibility.

Instructions for the Completion of the MR Waiver Plan of Care Summary Form (DMAS-438)

An **abbreviated** Plan of Care Summary must accompany the Enrollment Request form to be considered for MR Waiver. Information that must be completed and sent **along with the Enrollment Request form submission** is designated below with an asterisk (*). See highlighted Plan of Care Summary form for information required during enrollment.

Items **not** marked with an asterisk are to be completed following written notification from DMHMRSAS that the individual has been approved for enrollment. This **fully completed** Plan of Care Summary form is to be submitted to DMHMRSAS, along with the appropriate ISARs in order to complete authorization of services.

1. * Identifying information

- **Consumer Name:** in the appropriate boxes enter consumer's last name, first name and middle initial
- **CSP Start Date:** enter the start date of the Case Manager's plan for this year. This may be earlier than the actual start date of **Waiver** services, but must be used to determine the quarterly review dates and annual reassessment date for the individual's CSP. All MR Waiver services that begin during the CSP year will follow this review/assessment cycle.
- **Medicaid Number:** enter the consumer's **12 digit** number
- **Date of last Medical Exam:** Enter the date the consumer last had a comprehensive physical exam, in the order "month-day-year." A medical exam must be completed within one year prior to the actual start of Waiver services. The individual may be approved for enrollment without a current medical, but actual services will not be authorized until/unless the "no longer than one-year prior" timeframe is met.
- **CSP End Date:** enter the end date for the CSP (no more than 365 days [366 in leap years] from the CSP start date). This should be the annual end date of the case management plan.
- **CSB:** enter the name of the CSB providing (or contracting for) case management services
- **Case Manager:** enter the name of the consumer's case manager
- **Phone:** enter the phone number of the consumer's case manager, including the area code.

NOTE: The consumer name and Medicaid number must be entered on the top of page 2 as well.

2. * ***Primary goals of the consumer***

Enter the goals set by the consumer and his/her support team for this CSP year. These are **not** necessarily the objectives in Individual Service Plans, but the consumer's desired long-term outcomes, which will be accomplished through the completion of all ISP objectives.

3. ***Living Arrangements***

Check what the consumer's living situation will be while receiving MR Waiver services. Please be careful with the response. Critical pre-authorization decisions will be made based on this information.

4. * ***ICF/MR Level of Functioning***

- Enter the most recent date of completion of the LOF. It must be completed no earlier than 6 months prior to the start of MR Waiver services.
- Check the LOF categories met by the consumer. The consumer must meet at least 2 in order to qualify for MR Waiver services.

2. ***ICAP***

- If the ICAP was completed for the individual, enter the General Maladaptive Index score (GMI), the Service Score, and the date it was completed.
- If another DMHMRSAS- approved assessment was completed for the individual, attach the results to the POC Summary.

2. ***Range of services/supports that this individual receives or will receive***

- * For the ***abbreviated*** POC Summary for Enrollment purposes only, only the "***Amount/Frequency***" column must be completed at this time. Enter the ***expected*** amount and frequency information (e.g., 50 hours/wk) for each service requested by and appropriate for the consumer and family.

Following notification of approval for enrollment and in preparation for authorization, complete the following:

- For each service requested by the consumer and family for Waiver funding, as well as each service or support received by the consumer through other funding mechanisms, enter the ***Provider Name, amount/frequency*** to be provided and requested ***start date***. All regularly provided or other necessary non-Waiver services must be included as well.

NOTE: All Waiver services other than Therapeutic Consultation services, Environmental Modifications and Assistive Technology include an extra line in the event of two providers of the same service. In the unusual event of more than 2 providers (or two providers of TC, EM or AT) attach additional pages.

2. * ***Case Manager Signature***

The case manager must sign and date the form for enrollment and service authorization purposes (i.e., when re-submitting the ***fully completed*** form for authorization of services, an updated signature & date should be entered; the same form may be used).

GENERAL INSTRUCTIONS FOR THE COMPLETION OF INDIVIDUAL SERVICE AUTHORIZATION REQUEST FORMS

For use on **ALL** ISAR forms:

Please ensure that EVERY applicable space has been completed and handwritten forms are printed legibly. Incomplete (or unreadable) submissions will be pended until complete information is received.

1. Check the appropriate box(es) in the upper left corner to indicate which of the following this ISAR is to accomplish:
 - **Initiate:** this is the first time **any** MR Community Waiver services are requested for this consumer. Check this on all ISARs that are submitted at the same time when beginning MR Waiver services for the consumer.
 - **Terminate:** the consumer will no longer receive **this specific** Waiver service and/or by this specific provider.
 - **Modify:** the request is for change(s) in previously authorized services, including an increase/decrease of hours, starting a new service, changing providers, etc. **Always** include an explanation of the circumstances requiring a service or provider modification in the “Comments” section of the ISAR and/or attach additional pages as necessary.
 - **Emergency:** this request represents an emergency situation.
1. Include the **CSB name** and **CSB provider number** in the upper right corner as indicated. The ISAR cannot be processed without this information.
2. **Provider Name:** indicate the name of the DMAS provider for this service
3. **Provider Number:** indicate the DMAS provider number for the provider of this service.
4. **Name:** enter the name of the consumer to receive this Waiver service in the order last, first, middle initial.

5. ***Start:*** enter the start date of this Waiver service
6. ***End:*** enter the end date of the CSP period (see the CSP end date on the Plan of Care Summary and as described in #2 of POC Summary instructions).
7. ***Medicaid Number:*** enter the **12-digit** number for the consumer of this service
8. ***Check Service to be Provided (for which authorization is requested):*** enter a check mark in the box next to the appropriate billing code to be received by this consumer (or service type, as appropriate, except for Personal Assistance, in which no other designation is needed).
9. ***Weekly/Yearly Hours/Units or Cost:*** For most Waiver services, enter the requested number of hours of service per week, multiply this by 52 (weeks) and enter the total number of yearly hours requested. For two services (Assistive Technology and Environmental Modifications), enter the total cost of the item or modification for this request.
10. ***What Support Needs Does this Person Have. . . ?:*** Briefly describe the consumer's specific needs, as included in the ISP and/or Social Assessment and related to the primary goals on the Plan of Care Summary form, to be addressed through this service.
11. ***Comments:*** enter any explanatory remarks or comments necessary, and helpful for pre-authorization of services, in spaces provided. On forms on which a comments section is not provided (and in situations in which the comments section is insufficient), please attach additional pages, as necessary for explanation.

At the bottom of each ISAR:

12. ***Name of Provider Agency Representative:*** enter the name of the person completing the ISAR
13. **Signature of Representative:** the agency representative must sign the form.
14. ***Date:*** enter the date the form was completed
15. ***Responsible CSB Representative/Case Manager:*** enter the name of the case manager or other responsible CSB staff
16. ***Signature:*** the case manager or other responsible CSB staff must sign the form, assuring that the above information on the form has been reviewed and is appropriate for the consumer

17. *Phone No:* enter the phone number at which the case manager can be reached.
18. *FAX No:* enter the fax number for the case manager.
19. *Date:* the case manager or other responsible CSB staff reviewed and signed the ISAR.

ADDITIONAL INSTRUCTIONS FOR MR WAIVER 60 DAY ASSESSMENT ISAR (DMAS-439)

“Enter Periodic Support hours per week”: If Periodic Support hours will be incorporated into the requested amount of Residential Support or Personal Assistance hours for this consumer, enter the Periodic Support hours/week from the Determining Periodic Support Hours sheet (also a Chapter IV Exhibit).

“Enter total of Periodic Support hours + regular hours”: If using Periodic Support hours, total the two figures above this line on the ISAR to get a grand total of weekly hours (inclusive of Periodic Support hours). Multiply this by 52 to get the requested yearly total.

“Check the allowable activities. . .” :

- For any service to be authorized through this ISAR, only the activities **included in the consumer’s Assessment ISP**, which are represented in this box should be checked.
- The total number of hours per day during which the consumer will be engaged in the allowable activities should be entered in the appropriate days’ boxes to the right. Entry should be a **single number** (vs. a time span or series of numbers associated with each allowable activity). Providers may include, in this section only, the total actual hours of service provided on each day, even if Waiver does not reimburse for all of them.
- If the 60 Day Assessment ISAR is for *Day Support or Supported Employment* and a portion of the time to be billed will be spent in transporting the consumer to and from the DS or SE program, the billable amount of transportation time may be entered in the appropriate days’ boxes below the service hours boxes.

Additional Instructions for the Completion of MR Waiver Assistive Technology ISAR (DMAS-447)

1. “***Note previous expenses this CSB yr.***” because Assistive Technology is limited to a \$5000.00 expenditure each CSP year, including on the ISAR other AT expenses for this CSP year will ensure compliance with funding limitations.
2. “***. . . requested and denied under Medicaid SPO Durable Medical Equipment?***”: indicate by checking “yes” or “no” whether DME payment for the item has been investigated, explaining the outcome of either answer. If an item was not requested/denied through this process, but its availability through DME was investigated, please explain.
3. “***Check the following. . .***” : check which type(s) of allowable equipment or activity is being requested for funding (including an explanation for the need for Rehabilitation Engineering
4. “***Describe the specific modifications. . .***”: describe fully the items or services being requested for funding.

Additional Instructions for the Completion of MR Waiver Day Support ISAR (DMAS-442)

1. “Check the allowable activities. . .”
 - “***If High Intensity. . .***” : If requesting High Intensity Day Support services (i.e., Z8557 or Z8561 checked above), check the category(ies) for which documentation exists qualifying the consumer for this higher intensity service.
 - “***Training in Functional Skills***”: check all allowable activities for which the ISP includes training objectives.
 - “***Assistance and Supervision***”: check all allowable activities for which the ISP includes assistance objectives/statements.
 - ***Prevocational Training***: check if the services provided under Day Support are prevocational in nature.
 - If the ISAR is for *prevocational training under Day Support*, check “yes” or “no” to indicate whether these services can be obtained from another source as listed.
 - The total number of hours per day during which the consumer will be engaged in the allowable activities should be entered in the appropriate days’ boxes to the right. Entry should be a **single number** (vs. a time span or series of numbers associated with each allowable activity).
 - If a portion of the time to be billed will be spent in transporting the consumer to and from the DS program, the billable amount of transportation time may be entered in the appropriate days’ boxes below the service hours boxes.

Additional Instructions for the Completion of MR Waiver Environmental Modification ISAR (DMAS-446)

1. ***“Note previous expenses this CSB yr.”*** because Environmental Modification is limited to a \$5000.00 expenditure each CSP year, including on the ISAR other EM expenses for this CSP year will ensure compliance with funding limitations.
2. ***“Check the following. . .”*** : check which type(s) of allowable equipment or activity is being requested for funding (including an explanation for the need for Rehabilitation Engineering.
3. ***“Describe the specific modifications. . .”***: describe fully the items or services being requested for funding.

Additional Instructions for the Completion of MR Waiver PERSONAL ASSISTANCE ISAR (DMAS-443)

1. “***Enter Periodic Support hours per week***”: If Periodic Support hours will be incorporated into the requested amount of Personal Assistance hours for this consumer, enter the Periodic Support hours/week from the Determining Periodic Support Hours sheet (also a Chapter IV Exhibit).
2. “***Enter total of Periodic Support hours + regular hours***”: If using Periodic Support hours, total the two figures above this line on the ISAR to get a grand total of weekly hours (inclusive of Periodic Support hours). Multiply this by 52 to get the requested yearly total.
3. “***Does the individual need training. . .***”: check yes or no (*this should be determined by the consumer’s team. MR Waiver policy requires that consumers receiving Personal Assistance who are in need of training receive that training in some other setting. If not, Personal Assistance may not be authorized.).
4. “***If yes, in what other service. . .***”: indicate the context in which the consumer’s training needs will be met (e.g., DS, SE, school, etc.).
5. “***Check the allowable activities. . .***”
 - “***Assistance with. . .***”: check all allowable activities for which the ISP includes assistance objectives/activities.
 - “***Supervision. . .***” check if ISP includes this activity.
 - The total number of hours per day during which the consumer will be engaged in the allowable activities should be entered in the appropriate days’ boxes to the right. Hours planned for assistance activities are entered in the top boxes and hours planned for general supervision are entered in the bottom boxes.

Entry should be a **single number** (vs. a time span or series of numbers associated with each allowable activity). Providers may include, in this section only, the total actual hours of service provided on each day, even if Waiver does not reimburse for all of them.

Additional Instructions for the Completion of MR Waiver RESIDENTIAL SUPPORT ISAR (DMAS-440)

1. ***“Enter Periodic Support hours per week”***: If Periodic Support hours will be incorporated into the requested amount of Residential Support hours for this consumer, enter the Periodic Support hours/week from the Determining Periodic Support Hours sheet (also a Chapter IV Exhibit).

1. ***“Enter total of Periodic Support hours + regular hours”***: If using Periodic Support hours, total the two figures above this line on the ISAR to get a grand total of weekly hours (inclusive of Periodic Support hours). Multiply this by 52 to get the requested yearly total.

2. ***“Check the allowable activities. . .”***
 - ***“Training in Functional Skills”***: check all allowable activities for which the ISP includes training objectives.

 - ***“Assistance and specialized supervision”***: check all allowable activities for which the ISP includes assistance/specialized supervision objectives/statements.

 - ***“Nighttime Specialized Supervision”***: explain the consumer’s need based on historical data and explain what the staff will do to implement PM specialized supervision.

 - The total number of hours per day during which the consumer will be engaged in the allowable activities should be entered in the appropriate days’ boxes to the right. Hours planned for training and assistance activities are entered in the top boxes and hours planned for nighttime specialized supervision are entered in the bottom boxes.

Entry should be a **single number** (vs. a time span or series of numbers associated with each allowable activity).). Providers may include, in this section only, the total actual hours of service provided on each day, even if Waiver does not reimburse for all of them.

Additional Instructions for the Completion of MR Waiver SUPPORTED EMPLOYMENT ISAR (DMAS-441)

“Check the allowable activities. . .”

- *“Training in Specific Skills. . .”*: check all allowable activities for which the ISP includes training objectives.
- *“There is documentation. . .”*: check “yes” or “no” to indicate whether these services can be obtained from another source as listed. If no documentation of this nature exists, the service will be denied.
- The total number of hours per day during which the consumer will be engaged in the allowable activities should be entered in the appropriate days’ boxes to the right. Entry should be a **single number** (vs. a time span or series of numbers associated with each allowable activity).
- If a portion of the time to be billed will be spent in transporting the consumer to and from the SE site, the billable amount of transportation time may be entered in the appropriate days’ boxes below the service hours boxes.

Additional Instructions for the Completion of MR Waiver THERAPEUTIC CONSULTATION ISAR (DMAS-445)

1. “*Service to be provided*”: indicate by checking, what type of consultation service will be provided. Only one type may be checked per ISAR. Additional ISARs are needed for more than one Therapeutic Consultation request, even if the same provider will provide both services.
2. “*Check the allowable activities. . .*”
 - “*Assessment/evaluation*”: check all allowable activities that are reflected by a planned activity on the ISP.
 - “*Training, consultation and . . .*”: check all allowable activities which are reflected by a planned activity on the ISP.
 - “*Assistance in design & integration. . .*”: check all allowable activities which are reflected by a planned activity on the ISP.
 - The total number of hours per year which are estimated to be required for the various categories of allowable activities should be entered in the appropriate boxes to the right. Entry should be a **single number** in each box (vs. a time span or series of numbers associated with each allowable activity).

Additional Instructions for the Completion of MR Waiver RESPITE ISAR (DMAS 444)

1. “***Service to be provided***”: indicate by checking, in what type of setting the Respite services will be provided.
2. “***Check the allowable activities. . .***”
 - “***Assistance with. . .***”: check all allowable activities for which the ISP includes assistance objectives/activities.
 - “***Supervision. . .***” check if the ISP includes this activity.

**Additional Instructions for the Completion of MR Waiver
NURSING ISAR (DMAS 448)**

“Check the allowable activities. . .”: check all allowable activities represented on the ISP.

Additional Instructions for the Completion of MR Waiver CRISIS STABILIZATION ISAR (DMAS-430)

Page 1

1. “***Check Service to be Provided***”: indicate if a **different provider** will be delivering Crisis Supervision than will be delivering Crisis Intervention by entering the Crisis Supervision provider’s name and provider number under the “Z code” for that service. This is the only service in which two providers may be included on one ISAR.
2. “***Days used this calendar year***”: indicate the number of days Crisis Stabilization has been used already this calendar year (maximum of 60 days/year).
3. “***Documentation in the case record. . .***”: check all that apply to the consumer at this time.
4. “***The individual is at risk of***”: check all that apply to the consumer at this time.
5. “***. . . Assessment/reassessment . . . completed by . . . qmrp***”: indicate by checking whether this was an initial assessment for the service, or a reassessment of the consumer for his/her continuing need for Crisis Stabilization over the course of the same incident. Indicate the qmrp’s name, agency and date of assessment/reassessment.
6. “***An Individual Service Plan outlining. . .***”: indicate the status of the ISP as received by the case manager or expected to be received by the case manager. One of these two boxes must be checked.

Page 2

7. “***Check the following allowable activities. . .***”: check all allowable activities represented on the ISP(s).
8. ***Signatures*** are required of the agency representatives of **both** the provider of Clinical Intervention and the provider of Crisis Supervision.

NAME: _____

Address: _____

City: _____ **VA. Zip Code:** _____

Date of Approval by DMHMRSAS: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DMHMRSAS Representative: _____

Date: _____

Phone: _____

**PROCEDURES FOR SPECIAL CARE DELIVERY FOR CONSUMER
DIRECTED PERSONAL CARE OR RESPITE CARE**

CD Services Facilitator Responsibilities

It is the CD Services Facilitator's responsibility to assure that the assistant hired by the individual or family caregiver has received adequate training in performing any of the following required activities.

While assistance with bowel/bladder programs, range of motion exercises, routine wound care which does not include sterile technique, and external catheter care are permitted for these services none of these procedures may be administered except as part of a physician-ordered program.

In addition to the typical information that must be documented in the CD Services Facilitator's routine visit summary, these areas, when they are part of an individual's ISP, require special documentation by the CD Services Facilitator:

- A. **Bowel and Bladder Program**—A written physician's order in the individual's file must specify the method and type of digital stimulation and frequency of administration. The CD Services Facilitator must document that the assistant has received special training in bowel and bladder program management, has knowledge of the circumstances that require immediate reporting to the RN Services Facilitator, and that the RN Services Facilitator has observed the assistant performing this function. The assistant's continuing understanding and ability to perform bowel and bladder programs must also be documented in the routine visit note.
- B. **Range of Motion Exercises**—The written physician order, which indicates the need and extent of range of motion exercises to be performed, must be in the individual's file. The CD Services Facilitator must document in the individual's record that the assistant has been instructed by the RN CD Services Facilitator in the administration of maintenance range of motion exercises and that the assistant's correct performance of these exercises has been witnessed and documented by the RN CD Services Facilitator. The continued need for range of motion exercises and the monitoring of the assistant's performance of these exercises must be noted in the routine visit note.
- C. **Routine Wound Care**—During each visit, the CD Services Facilitator must document the status of the wound and the monitoring of the individual's care.
- D. **Catheter Care**—When routine care of an external condom catheter is to be provided by the assistant, the CD Services Facilitator must indicate in the initial comprehensive visit note that the assistant is providing condom care and what instructions the assistant has received regarding this care. Documentation must indicate the assistant's ability to perform this procedure.

Parameters for the Personal Assistant or Respite Assistant

Bowel/bladder programs: Administration of bowel and bladder programs by the assistant under special training and supervision is permitted. The personal assistant may be authorized to administer physician-ordered bowel and bladder programs to individuals who do not have other support available. This authorization may only be given for these reasons:

- The CD Services Facilitator has documented that the assistant has received special training in bowel and bladder program management;
- The assistant has knowledge of the circumstances that require immediate reporting to the individual's physician; and
- The RN contracted by the Services Facilitator has observed the assistant performing this function.

The bowel program may include, if necessary, a laxative, enemas, or suppositories to stimulate defecation. However, the laxative cannot be "administered" by the personal assistant, even through part of the bowel program (suppositories are an exception to this and can be administered if ordered by the physician as part of a bowel program). Certain conditions exist that would contraindicate having the assistant perform a bowel program (e.g., patients prone to dysreflexia such as high level quadriplegics, head and spinal-cord-injured patients, and some stroke patients).

Replacement of a colostomy bag as part of the bath is permitted. Digital stimulation and removal of feces within the rectal vault may be a necessary part of the bowel maintenance or training program. However, removal of impacted material is not permitted.

The bladder program may not include any invasive procedures such as catheterization, instillation or irrigation, but can include bladder-training activities. Bladder retraining is limited to time management of urination without any invasive procedures or voiding stimulation. The RN contracted by the CD-Services Facilitator must be available to the assistant and be able to respond to any complications immediately;

Administration of range of motion exercises: Range of motion exercises ordered by the physician may be performed by the assistant when the assistant has been instructed by the RN in the administration of maintenance of range of motion exercises, and the assistant's correct performance of these exercises has been witnessed and documented by the RN. This does not include strengthening exercises or exercises aimed at retraining muscle groups, but includes only those exercises used to maintain current range of movement without encountering resistance;

Routine wound care that does not include sterile technique: The assistant can perform routine wound care that does not include sterile treatment or sterile dressings. This would include care of a routine decubitus, defined as a decubitus which is superficial or does not exceed stage 2 (sore penetrates to the underlying subcutaneous fat layer, shows redness, edema, and induration, at times with epidermal blistering or desquamation). Normal wound care would include flushing with normal saline solution, washing the area, drying the area, and applying dry dressings as instructed by the nurse

supervisor. This does not include the application of any creams, ointments, sprays, powders, or occlusive dressings;

Monitoring vitals: Checking the temperature, pulse, respiration, and blood pressure and recording and reporting, as required, is permitted.

DMAS will **not** reimburse personal or respite assistants for any of the following activities:

Skilled Services: Services requiring professional skills or invasive therapies such as tube feedings, Foley catheter irrigations, sterile dressings, or any other procedures requiring sterile technique, cannot be performed by personal assistants. Routine maintenance and care of external condom catheters does not constitute a skilled service and can be performed by the personal assistant as part of the bathing process.

DEVELOPMENTAL MILESTONES ASSESSMENT FOR CHILDREN UNDER THE AGE OF SIX AND AT DEVELOPMENTAL RISK

INSTRUCTIONS

“Detecting developmental delays early is challenging. Delays or deviations in development may come to the attention of professionals and parents because a child is known to have risk factors by history, has physical findings or medical conditions likely to be associated with delays, or manifests delays at the time of observations. A delay in a skill becomes evident only at the age when a specific developmental milestone is expected”. (1) “Child development is a dynamic process and is often hard to measure by its very nature”. (2) “A single test at one point in time only gives a snapshot of the dynamic process, making periodic screening necessary to detect emerging disabilities as a child grows”. (3)

1. Select the age-appropriate assessment tool.
2. In conjunction with the caretaker (parent, guardian, etc.) and recipient (if appropriate) address each item on the assessment tool.
3. Categories preceding the “Health Watch” category are ranked from left to right as Rarely, Sometimes, Often and Regularly. This is an attempt to maintain consistency with the adult LOF assessment tool.
4. Please note that “Health Watch” ratings are ranked from left to right as Regularly, Often, Sometimes, and Rarely. This is an attempt to adhere to the American Academy of Pediatrics Medical Library documents and also to provide the evaluator with specific data that they (or the caretaker) can share with the physician if necessary.
5. It is expected that the Developmental Milestones Assessment will be conducted as a recipient-centered, culturally sensitive process. The final product should include input from the caretaker, the recipient (if appropriate), the physician and any other service provider involved with the care/welfare of the recipient. This input may include interviews, telephone calls, copies of records, etc.
6. The following definitions should be adhered to when completing the assessment:

“Rarely” Behavior occurs quarterly or less
 “Sometimes” Behavior occurs one a month or less
 “Often” Behavior occurs 2-3 times per month
 “Regularly” Behavior occurs weekly or more

7. The Developmental Milestones are the typical stages of development for children. They are to be assessed to determine abilities, skills, and needs of the child and will be the basis for the development of a plan of care. A simple majority of ratings of “Sometimes” and “Rarely” within any one of the designated milestone categories places the child in the “at risk of developmental delay” population.

(1) *Committee on Children with Disabilities, American Academy of Pediatrics. Policy Statement: Developmental surveillance and Screening of Infants and Young Children (RE0062). Vol. 108, No. 1. July 2001. 192-196.*
 (2) *Committee on Children with Disabilities, American Academy of Pediatrics. 192-196.*
 (3) *Committee on Children with Disabilities, American Academy of Pediatrics. 192-196.*

8. Any ranking of “Often” or “Regularly” in the Health Watch category places the child in the “at risk of development delay” population.
9. Any child that meets the “at risk of development delay” criteria should be referred to a physician for further assessment.
10. Re-assessments should be conducted at least at each age-specified stage of development. Additional assessments should be conducted whenever there is significant change in the child’s functioning level.

Department of Mental Health, Mental Retardation and Substance Abuse Services

MR WAIVER PLAN OF CARE SUMMARY

| | | | | |
|--------------------|--|---|--|--|
| Individual's Name: | <div style="border: 1px solid black; padding: 2px; text-align: center;">LAST</div> | <div style="border: 1px solid black; padding: 2px; text-align: center;">FIRST</div> | <div style="border: 1px solid black; padding: 2px; text-align: center;">M.I.</div> | CSP Start Date: <div style="border: 1px solid black; width: 100px; height: 20px;"></div> |
| Medicaid Number: | <div style="border: 1px solid black; width: 150px; height: 20px;"></div> | Date of last medical exam: | <div style="border: 1px solid black; width: 80px; height: 20px;"></div> | CSP End Date: <div style="border: 1px solid black; width: 100px; height: 20px;"></div> |
| CSB: | <div style="border: 1px solid black; width: 150px; height: 20px;"></div> | Case Manager: | <div style="border: 1px solid black; width: 150px; height: 20px;"></div> | Phone: <div style="border: 1px solid black; width: 100px; height: 20px;"></div> |

Primary goals of the individual:

Living Arrangements (while in the MR Waiver)
Check any that apply:

- ☐ Lives alone
- ☐ In home/apartment shared with relatives or other
- ☐ DMHMRSAS-Licensed Supportive Residential
- ☐ DMHMRSAS-Licensed Group Home (2-4 persons)
- ☐ DMHMRSAS-Licensed Group Home (5 or more)
- ☐ DMHMRSAS-Licensed Sponsored Placement
- ☐ DSS-Approved Adult Foster/Family Care Home
- ☐ DSS-Licensed Assisted Living Facility
- ☐ DSS-Approved Child Foster Care Home
- ☐ Core-Licensed Children's Family Care Home
- ☐ Core-Licensed Children's Group Home
- ☐ Other (specify):

ICF/MR Level of Functioning

Date completed _____
Check the following categories in which dependency level is met (must be met in 2 or more within 6 months of start date)

- ☐ 1. Health Status
- ☐ 2. Communication
- ☐ 3. Task Learning Skills
- ☐ 4. Personal/Self Care

- ☐ 5. Mobility
- ☐ 6. Behavior
- ☐ 7. Community Living Skills

ICAP*

GMI
Service Score

Date Completed:

**Attach other assessment summary if ICAP not used.*

List the full range of services/supports that this individual receives/will receive:

| Service Type | Services/Supports | Provider Name | Amt / Frequency | Start Date |
|---|------------------------------------|---------------|-----------------|------------|
| WAIVER SERVICES | | | | |
| Case Management | | | | |
| If more than one provider, enter 2nd here Residential Support → | In-Home/Supported Living | | | |
| | Group Home | | | |
| | Group Home for Children | | | |
| | AFC | | | |
| | Sponsored Placement | | | |
| | | | | |
| If more than one provider, enter 2nd here Day Support → | Regular Intensity, Center-Based | | | |
| | Regular Intensity, Community-Based | | | |
| | High Intensity, Center-Based | | | |
| | High Intensity, Community-Based | | | |
| | | | | |
| If more than one provider, enter 2nd here Prevocational → | Regular Intensity, Center-Based | | | |
| | Regular Intensity, Community-Based | | | |
| | High Intensity, Center-Based | | | |
| | High Intensity, Community-Based | | | |
| | | | | |

Individual's Name: Medicaid #:

LAST FIRST M.I.

| Service Type | Services/Supports | Provider Name | Amt / Frequency | Start Date |
|---|------------------------------------|---------------|-----------------|------------|
| WAIVER SERVICES (continued) | | | | |
| Supported Employment If more than one provider enter 2nd here → | Individual Placement | | | |
| | Group | | | |
| | | | | |
| Personal Assistance | Agency Directed | | | |
| | Consumer Directed | | | |
| Skilled Nursing If more than one provider enter 2nd here → | LPN | | | |
| | RN | | | |
| | | | | |
| Respite If more than one provider enter 2nd here → | In-Home | | | |
| | Out-of-Home | | | |
| | Residential | | | |
| | Center-Based | | | |
| | Consumer Directed | | | |
| | | | | |
| Companion | Agency Directed | | | |
| | Consumer Directed | | | |
| Therapeutic Consultation | Behavioral | | | |
| | Psychological | | | |
| | Physical | | | |
| | Speech | | | |
| | Occupational | | | |
| | Recreational | | | |
| | Rehabilitation Engineering | | | |
| Crisis Stabilization | Clinical / Behavioral Intervention | | | |
| | Crisis Supervision | | | |
| Environmental Modification | | | | |
| Assistive Technology | | | | |
| PERS (Personal Emergency Response System) | PERS | | | |
| | PERS and Medication Monitoring | | | |
| NON-WAIVER SERVICES | | | | |
| School | | | | |
| Medical | | | | |
| Mental Health | | | | |
| OT/PT/SP Therapy | | | | |
| Other | | | | |
| | | | | |
| | | | | |

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

Case Manager Signature _____

Date _____

- ☐ Initiate Waiver services
- ☐ Service Modification
- ☐ Add a service
- ☐ Increasing level/hours of service
- ☐ Decreasing level/hours of service
- ☐ Provider Modification (requires 2 ISARs)
- ☐ End a service

MR Waiver
Agency-Directed Companion Services
Individual Service Authorization Request

CSB _____

CSB provider # _____

Provider Name _____

Provider Number _____

Name: _____

Last,

First

MI

Start: _____

Date

End: _____

Date

Medicaid Number: _____

SERVICE TO BE PROVIDED

WEEKLY / YEARLY HOURS

OMR USE ONLY

Companion – Y0070

Hours / week

x 52

=

Yearly total (1)

Reason for the request: _____

Answer the questions and check the allowable activities included in the individual's plan. Indicate the *total* number of hours per day. Companion Services is limited to 8 hours per day.

Is there a therapeutic goal in the ISP?

☐ Yes☐ No

Is the individual age 18 or older?

☐ Yes☐ No**Assistance or support with**

- ☐ tasks such as meal preparation, laundry, shopping
- ☐ light housekeeping tasks
- ☐ self-administration of medication
- ☐ community access & recreational activities
- ☐ assuring the safety of the individual

SUN

MON

TUE

WED

THUR

FRI

SAT

Comments: _____

Name of Provider Agency Representative (print)

Signature

Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print)

Signature

Phone No.

Fax No.

Date

- ☐ Initiate Waiver service
☐ Service Modification (add a service)
☐ Provider Modification (requires 2 ISARs)
☐ End a service

MR Waiver 60-Day Assessment Individual Service Authorization Request

CSB _____

CSB provider # _____

Provider Name

Provider Number

Name:

Start:

End:

Last,

First

MI

Date

Date

Medicaid Number:

CHECK SERVICE TO BE PROVIDED
USE ONLY

WEEKLY / YEARLY HOURS / UNITS

OMR

| | | |
|---|---|--|
| <input type="checkbox"/> Z8595 Supported Living / In-Home | <div style="border-bottom: 1px solid black; width: 100%;"></div> Weekly Hours x 52 = <div style="border-bottom: 1px solid black; width: 100%;"></div> Yearly Hours | |
| <input type="checkbox"/> Z8551 Congregate (please specify below) <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Group Home <input type="checkbox"/> Adult Foster Care Home <input type="checkbox"/> Sponsored Placement </div> <div> <input type="checkbox"/> Group Home for Children <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Other: </div> </div> | <div style="border-bottom: 1px solid black; width: 100%;"></div> Weekly Hours x 52 = <div style="border-bottom: 1px solid black; width: 100%;"></div> Yearly Hours | |
| <input type="checkbox"/> Z4036 Personal Assistance | <div style="border-bottom: 1px solid black; width: 100%;"></div> Weekly Hours x 52 = <div style="border-bottom: 1px solid black; width: 100%;"></div> Yearly Hours | |
| Enter periodic support hours <i>per week</i> (if needed)—RS and PA only. | <div style="border-bottom: 1px solid black; width: 100%;"></div> Weekly Hours | |
| Enter total of periodic support hours + regular hours per week | <div style="border-bottom: 1px solid black; width: 100%;"></div> Weekly Hours x 52 = <div style="border-bottom: 1px solid black; width: 100%;"></div> Yearly Hours | |
| <input type="checkbox"/> Z8556 DS or <input type="checkbox"/> PREVOC Reg. Int. Center-Based <input type="checkbox"/> Z8557 DS or <input type="checkbox"/> PREVOC High Int. Center-Based <input type="checkbox"/> Z8560 DS or <input type="checkbox"/> PREVOC Reg. Int. Non-Center-Based <input type="checkbox"/> Z8561 DS or <input type="checkbox"/> PREVOC High Int. Non-Center-Based | <div style="border-bottom: 1px solid black; width: 100%;"></div> Weekly Units x 52 = <div style="border-bottom: 1px solid black; width: 100%;"></div> Yearly Units | |
| <input type="checkbox"/> Z8597 Supported Employment, Individual Placement | <div style="border-bottom: 1px solid black; width: 100%;"></div> Weekly Hours x 52 = <div style="border-bottom: 1px solid black; width: 100%;"></div> Yearly Hours | |
| <input type="checkbox"/> Z8598 Supported Employment, Enclave/Work Crew | <div style="border-bottom: 1px solid black; width: 100%;"></div> Weekly Units x 52 = <div style="border-bottom: 1px solid black; width: 100%;"></div> Yearly Units | |

While providing the agreed-upon supports and services, a 60-day assessment must be used to 1) evaluate the individual's needs and interests in the service environment and community settings and 2) develop an annual service plan. Why is this assessment period needed for this individual?

Check the allowable activities that are included in the plan. Indicate the *total* number of hours per day:

| Assessment of and assistance with: | SUN | Mon | Tues | Wed | Thur | Fri | Sat |
|---|-----|-----|------|-----|------|-----|-----|
| <input type="checkbox"/> participation in a variety of settings and activities <input type="checkbox"/> all life skill areas related to the service, including identification of personal preferences <input type="checkbox"/> health and safety issues | | | | | | | |
| <input type="checkbox"/> needs for nighttime specialized supervision (residential only) | | | | | | | |
| Travel with the individual to and from DS/SE/PREVOC program: (record if billing for this time; can be included up to 25% of the total time; to bill for a 3-unit day, a minimum of 7 hrs of other allowable activities is required; does not include training related travel in scheduled activities) | | | | | | | |

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

We, the undersigned, assure that the assessment ISP will be followed by the development and implementation of an annual ISP (approved by the individual) by the end of the 60-day period.

Name of Provider Agency Representative (print)

Signature

Date

In addition to the assurance above, I agree that the assessment plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/Case Manager (print)

Signature

Phone No.

Fax No.

Date

- ☐ Initiate Waiver services
☐ Service Modification
 ☐ Add a service
 ☐ Increasing level/hours of service
 ☐ Decreasing level/hours of service
☐ Provider Modification (requires 2 ISARs)
☐ End a service

MR Waiver Assistive Technology Individual Service Authorization Request

CSB _____

CSB provider # _____

Provider Name _____

Provider Number _____

Name: _____

Start: _____

End: _____

Last,

First

MI

Date

Date

Medicaid Number: _____

The individual must have at least one other MR Waiver service to receive this service.

CHECK SERVICE TO BE PROVIDED

COST

OMR USE ONLY

| | | |
|---|--|--|
| <input type="checkbox"/> Z8603 Assistive Technology; Rehab Engineer | | |
| <input type="checkbox"/> Z8604 Assistive Technology; Off Shelf Item | | |
| <input type="checkbox"/> Z8605 Assistive Technology; Supply Cost | | |

Maximum Expenses = \$5,000 per CSP year

Note previous expenses this CSP yr: _____

Reason for this request (attach documentation of recommendation by a qualified professional)

Have any of the following been requested and denied under Medicaid SPO Durable Medical Equipment? ☐ Yes ☐ No
 Explain:

Check the following as needed by the individual:

- ☐ Specialized medical equipment and ancillary equipment/supplies necessary for life support
☐ Durable/non-durable medical equipment and supplies
☐ Adaptive devices, appliances, and/or controls which enable an individual to be more independent in activities of daily living
☐ Equipment and devices which enable an individual to communicate more effectively
☐ Rehabilitation Engineering (reason needed:) _____

Describe the specific modifications, equipment, supplies and/or other services to be provided:

Comments:

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/Case Manager (print)

Signature

Phone No.

Fax No.

Date

- ☐ Initiate Waiver services
☐ Service Modification
 ☐ Add a service
 ☐ Increasing level/hours of service
 ☐ Decreasing level/hours of service
☐ Provider Modification (requires 2 ISARs)
☐ End a service

MR Waiver Environmental Modification Individual Service Authorization Request

CSB _____

CSB provider # _____

Provider Name _____

Provider Number _____

Name: _____

Last,

First

MI

Start: _____

Date

End: _____

Date

Medicaid No. _____

The individual must have at least one other MR Waiver service to receive this service.

CHECK SERVICE TO BE PROVIDED

COST

OMR USE ONLY

☐ Z8599 Environmental Mod; Rehab Engineer

☐ Z8600 Environmental Mod; Structural

☐ Z8601 Environmental Mod; Supply Cost Only

☐ Z8602 Environmental Mod; Transportation

Maximum Expenses = \$5,000 per CSP year

Note previous expenses this CSP yr: _____

Reason for this request: _____

Check the following as needed by the individual:

- ☐ Physical adaptation of a house or place of residence necessary to assure an individual's health & safety
☐ Physical adaptation of a house or place of residence which enable an individual to live in a non-institutional setting and to function with greater independence
☐ Environmental Modification to a work site (which exceeds the requirements of ADA) needed by an individual who is receiving MR Waiver Supported Employment
☐ Modification to the individual's primary vehicle
☐ Rehabilitation Engineering (reason needed): _____

Describe the specific modifications, equipment, supplies and/or other services to be provided:

Comments: _____

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print) _____

Signature _____

Phone No. _____

Fax No. _____

Date _____

- ☐ Initiate Waiver services
- ☐ Service Modification
 - ☐ Add a service
 - ☐ Increasing level/hours of service
 - ☐ Decreasing level/hours of service
- ☐ Provider Modification (requires 2 ISARs)
- ☐ End a service

CSB _____

CSB provider #

**MR Waiver Agency-Directed
Personal Assistance
Individual Service Authorization Request**

Provider Name

Provider Number

Name:

Start:

End:

Last,

First

MI

Date _____

Date

Medicaid Number:

SERVICE TO BE PROVIDED

WEEKLY / YEARLY HOURS

OMR USE ONLY

| | | |
|---|---|--|
| Personal Assistance – Z4036 | <div> <div>Hours / week</div> <div>x 52</div> <div>=</div> <div>Yearly total (1)</div> </div> | |
| <div>Enter periodic support hours per week (if needed) →</div> | <div>+</div> <div>Hours / week</div> <div>=</div> | |
| <div>Enter total of periodic support hours + regular hours per week →</div> | <div>Hours / week</div> <div>x 52</div> <div>=</div> <div>Yearly total (2)</div> | |

Reason for the request:

Answer the questions and check the allowable activities included in the individual's plan. Indicate the *total* number of hours per day.

| | | | | | | | | |
|--|--|---|-----|-----|-----|------|-----|-----|
| Does the individual need training and skills development? | | If Yes, in what other service or program is the training and skills development received? | | | | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Assistance with <input type="checkbox"/> activities of daily living <i>(Must need to receive PA)</i> <input type="checkbox"/> monitoring health status & physical condition <input type="checkbox"/> medication and/or other medical needs <input type="checkbox"/> meal preparation and eating <input type="checkbox"/> housekeeping activities <input type="checkbox"/> participating in recreational activities <input type="checkbox"/> appointments or meetings | | SUN | MON | TUE | WED | THUR | FRI | SAT |
| General Support <input type="checkbox"/> to assure health and safety of the individual | | | | | | | | |
| Comments: | | | | | | | | |
| | | | | | | | | |

Name of Provider Agency Representative (print)

Signature

Date _____

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print)

Signature

Phone No.

Fax No.

Date _____

- ☐ Initiate Waiver services
- ☐ Service Modification
- ☐ Add a service
- ☐ Increasing level/hours of service
- ☐ Decreasing level/hours of service
- ☐ Provider Modification (requires 2 ISARs)
- ☐ End a service

MR Waiver Residential Support Individual Service Authorization Request

CSB _____

CSB provider # _____

| | | | | | |
|------------------------|-------|----|-----------------|------|------------|
| Provider Name | | | Provider Number | | |
| Name: _____ | | | Start: _____ | | End: _____ |
| Last, | First | MI | Date | Date | |
| Medicaid Number: _____ | | | | | |

| CHECK SERVICE TO BE PROVIDED | WEEKLY / YEARLY HOURS | OMR USE ONLY |
|---|---|--------------|
| <input type="checkbox"/> Z8595 Supported Living / I n-Home <input type="checkbox"/> Z8551 Congregate (please specify below) <div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> Group Home</div> <div><input type="checkbox"/> Group Home for Children</div> </div> <div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> Adult Foster Care Home</div> <div><input type="checkbox"/> Assisted Living Facility</div> </div> <div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> Sponsored Placement</div> <div><input type="checkbox"/> Other: _____</div> </div> | <div style="border-bottom: 1px solid black; text-align: center;">Hours / week</div> <div style="display: flex; align-items: center; justify-content: center;"> <div style="margin: 0 10px;">x</div> <div style="margin: 0 10px;">52</div> <div style="margin: 0 10px;">=</div> <div style="border-bottom: 1px solid black; text-align: center;">Yearly total (1)</div> </div> | |
| <div style="border: 1px solid black; padding: 5px;"> Enter periodic support hours per week (if needed) → </div> | <div style="text-align: center;">+</div> <div style="border-bottom: 1px solid black; text-align: center;">Hours / week</div> <div style="text-align: center;">=</div> | |
| <div style="border: 1px solid black; padding: 5px;"> Enter total of periodic support hours + regular hours per week → </div> | <div style="border-bottom: 1px solid black; text-align: center;">Hours / week</div> <div style="display: flex; align-items: center; justify-content: center;"> <div style="margin: 0 10px;">x</div> <div style="margin: 0 10px;">52</div> <div style="margin: 0 10px;">=</div> <div style="border-bottom: 1px solid black; text-align: center;">Yearly total (2)</div> </div> | |

Reason for this request: _____

Check the allowable activities that are included in the individual's plan. Indicate the *total* number of hours of program time per day.

| | Sun | Mon | Tues | Wed | Thur | Fri | Sat |
|---|-----|-----|------|-----|------|-----|-----|
| Training in Functional Skills <input type="checkbox"/> personal care and activities of daily living; <input type="checkbox"/> use of community resources; <input type="checkbox"/> adaptive behavior for home and community environments | | | | | | | |
| Assistance and specialized supervision (excluding nighttime) with <input type="checkbox"/> personal care <input type="checkbox"/> activities of daily living, use of community resources <input type="checkbox"/> medication, med needs, monitoring health & physical condition <input type="checkbox"/> travel to & from training sites and community resources | | | | | | | |
| Nighttime Specialized Supervision -- If applicable, indicate hours needed and provide explanation: | | | | | | | |
| What will staff do for Nighttime Specialized Supervision? | | | | | | | |

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

| | | |
|--|-----------|------|
| Name of Provider Agency Representative (print) | Signature | Date |
|--|-----------|------|

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

| | | | | |
|-------------------------------|-----------|-----------|---------|------|
| CSB Rep/ Case Manager (print) | Signature | Phone No. | Fax No. | Date |
|-------------------------------|-----------|-----------|---------|------|

- ☐ Initiate Waiver services
- ☐ Service Modification
- ☐ Add a service
- ☐ Increasing level/hours of service
- ☐ Decreasing level/hours of service
- ☐ Provider Modification (requires 2 ISARs)
- ☐ End a service

MR Waiver Supported Employment Individual Service Authorization Request

CSB _____

CSB provider # _____

Provider Name _____

Provider Number _____

Name: _____

Start: _____

End: _____

Last,

First

MI

Date

Date

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED

WEEKLY / YEARLY HOURS OR UNITS

OMR USE ONLY

☐ Z8597 Supported Emp, Individual Placement

Hours / week x 52 = Yearly total

☐ Z8598 Supported Emp., Group

Units / week x 52 = Yearly total

Reason for this request: _____

Check the allowable activities that are included in the individual's plan.

- ☐ Individualized assessment & development of employment related goals
- ☐ Individualized job development
- ☐ On-the-job training in work & work-related skills required to perform the job
- ☐ Ongoing evaluation, supervision and monitoring of job performance beyond supervisor's responsibilities
- ☐ Ongoing support services necessary to assure job retention
- ☐ Training in related skills essential to obtaining & retaining employment
- ☐ Travel with the individual to and from work sites, when other travel assistance unavailable
- ☐ Other: _____

There is documentation in the record that Supported Employment Services cannot be obtained from the school system (for those less than 22 years) nor from Department of Rehabilitative Services? ☐ Yes ☐ No

Record the number of hours per day of the following:

SUN

MON

TUES

WED

THU

FRI

SAT

(FOR BIWEEKLY/VARIED SCHEDULES, DRAW A LINE TO INDICATE DIFFERENT WEEKS)

TOTAL HOURS OF PROGRAM TIME

(e.g., if individual is in program from 8 a.m. until noon, enter "4")

Travel with the individual to & from program:

[record if billing for this time; can be included up to 25% of the total time; to bill for a 3-unit day, a minimum of 7 hrs of other allowable activities is required; does not include training related travel in scheduled activities]

Comments: _____

Name of Provider Agency Representative (print)

Signature

Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/Case Manager (print)

Signature

Phone No.

Fax No.

Date

- ☐ Initiate Waiver services
- ☐ Service Modification
- ☐ Add a service
- ☐ Increasing level/hours of service
- ☐ Decreasing level/hours of service
- ☐ Provider Modification (requires 2 ISARs)
- ☐ End a service

MR Waiver Therapeutic Consultation Individual Service Authorization Request

CSB _____

CSB provider # _____

Provider Name _____

Provider Number _____

Name: _____

Start: _____

End: _____

Last,

First

MI

Date

Date

Medicaid Number: _____

Only Behavioral Consultation may be provided in the absence of other MR Waiver services.

CHECK SERVICE TO BE PROVIDED

HOURS NEEDED

OMR USE ONLY

Z8565 Therapeutic Consultation

- ☐ Behavioral
- ☐ Psychological
- ☐ Speech
- ☐ Occupational
- ☐ Physical
- ☐ Recreational
- ☐ Rehabilitation Engineering

Reason for this request:

Check the allowable activities that are included in the individual's plan. Indicate the approximate total number of hours.

| (May not be direct therapy, evaluations, or services available through the Medicaid State Plan.) | Hours needed in each area |
|--|---------------------------|
| Assessment/evaluation: <input type="checkbox"/> interviewing to identify issues to be addressed/desired outcomes | |
| Training, consultation & technical assistance to program staff/family: <input type="checkbox"/> training in better supporting the individual through enhanced observations of environment/routines/interactions <input type="checkbox"/> reviewing documentation & evaluating staff/family activities <input type="checkbox"/> demonstrating/training in specialized therapeutic interventions or use of assistive devices | |
| Assistance in design & integration of individual objectives as part of the overall individual program planning process: <input type="checkbox"/> designing & developing a written Support Plan <input type="checkbox"/> making recommendations related to specific devices/technology or adapting other training programs/activities | |

Comments: _____

Name of Provider Agency Representative (print) _____

Signature _____

Date _____

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print) _____

Signature _____

Phone No. _____

Fax No. _____

Date _____

- ☐ Initiate Waiver services
- ☐ Service Modification
- ☐ Add a service
- ☐ Increasing level/hours of service
- ☐ Decreasing level/hours of service
- ☐ Provider Modification (requires 2 ISARs)
- ☐ End a service

MR Waiver Agency-Directed Respite Individual Service Authorization Request

CSB _____

CSB provider # _____

Provider Name _____

Provider Number _____

Name: _____

Last,

First

MI

Date

End: _____

Date

Medicaid Number: _____

SERVICE TO BE PROVIDED

HOURS NEEDED

OMR USE ONLY

Z9421 Respite

- ☐ In-Home
- ☐ Center-Based
- ☐ Out-of-Home
- ☐ Residential

Reason for this request: _____

Check the allowable activities that are included in the individual's plan.

(Not available to individuals living with paid caregivers; cannot be provided by Foster/Family Care providers to their own resident. Maximum 720 Respite hours per year, including CD Respite.)

Assistance with:

- ☐ activities of daily living;
- ☐ monitoring health status & physical condition;
- ☐ medication and/or other medical needs;
- ☐ meal preparation & eating;
- ☐ housekeeping activities;
- ☐ participating in recreational activities; and/or
- ☐ appointments/meetings

Support:

- ☐ to assure health & safety of the individual

Comments: _____

Name of Provider Agency Representative (print) _____

Signature _____

Date _____

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print) _____

Signature _____

Phone No. _____

Fax No. _____

Date _____

☐ Initiate Waiver services

51

☐ Service Modification

CSB _____

CSB provider # _____

☐ Add a service

☐ Increasing level/hours of service

☐ Decreasing level/hours of service

☐ Provider Modification (requires 2 ISARs)

☐ End a service

MR Waiver Skilled Nursing Services Individual Service Authorization Request

Provider Name _____

Provider Number _____

Name: _____

Start: _____

End: _____

Last,

First

MI

Date

Date

Medicaid Number: _____

CHECK ☒ SERVICE TO BE PROVIDED

WEEKLY / YEARLY HOURS

OMR USE ONLY

☐ Z9401 Skilled Nursing – RN

Hours / week

x 52 =

Yearly total

☐ Z9402 Skilled Nursing – LPN

Hours / week

x 52 =

Yearly total

Reason for this request: _____

Check the allowable activities included in the individual's plan.

(Must have documentation of medical necessity by a physician; short term skilled nursing needs should be covered under the Medicaid State Plan.)

☐ Monitoring individual's medical status

☐ Administering medication or other medical treatment

☐ Training family members, staff or other persons to monitor individual's medical status

☐ Training family members, staff or other persons to administer medications

☐ Training family members, staff or other persons to perform medically related procedures

Comments: _____

Name of Provider Agency Representative (print)

Signature

Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print)

Signature

Phone No.

Fax No.

Date

- ☐ Initiate Waiver services
- ☐ Service Modification
- ☐ Add a service
- ☐ Increasing level/hours of service
- ☐ Decreasing level/hours of service
- ☐ Provider Modification (requires 2 ISARs)
- ☐ End a service

MR Waiver Crisis Stabilization Individual Service Authorization Request

CSB _____

CSB provider # _____

Provider Name _____

Provider Number _____

| | | |
|---|--------------|------------|
| Name: _____ | Start: _____ | End: _____ |
| Last First MI | Date | Date |

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED

HOURS NEEDED

OMR USE ONLY

☐ Z8999 Clinical/Behavioral Intervention
[15 day limit; maximum 60 days in calendar yr]

☐ Z8899 Crisis Supervision
[allowable only if Z8999 is provided]

► **Provider** (if different):

Name: _____

Number: _____

Days used this calendar year: _____**Reason for this request:** _____**Documentation in the case record indicates the individual:** (Check all that apply; must meet at least one)

- ☐ is experiencing marked reduction in psychiatric, adaptive or behavioral functioning
- ☐ is experiencing extreme increase in emotional distress
- ☐ needs continuous intervention to maintain stability
- ☐ is causing harm to self or others

The individual is at risk of: (Check all that apply; must meet at least one)

- ☐ psychiatric hospitalization
- ☐ emergency ICF/MR placement
- ☐ disruption of community status (living arrangement, day placement, school)
- ☐ causing harm to self or others

A face-to-face ☐ assessment ☐ reassessment was completed by a qualified qmrp:

Name _____

Agency _____

Date _____

An Individual Service Plan outlining the specific activities of professionals and staff:

- ☐ has been received by the case manager.
- ☐ will be received within 72 hours of the assessment/reassessment by the qmrp.

Individual Name: _____

Last

First

MI

CHECK THE FOLLOWING ALLOWABLE ACTIVITIES INCLUDED IN THE INDIVIDUAL'S PLAN.

- ☐ Psychiatric, neuropsychiatric, psychological assessment & other functional assessments & stabilization techniques
☐ Medication management & monitoring
☐ Behavior assessment & behavior support
☐ Intensive care coordination with other agencies/providers to assist in planning & delivery of services & supports to maintain community placement of individual
☐ Training of family members, other care givers & service providers in positive behavioral supports to maintain the individual in the community

I

- ☐ Temporary crisis supervision to ensure the safety of the individual and others

Comments: _____

Name of Provider Agency Representative/Clinical Intervention
(print)

Signature

Date

Name of Provider Agency Representative/ Crisis Supervision
(print)

Signature

Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print)

Signature

Phone No.

Fax No.

Date

- ☐ Initiate Waiver services
- ☐ Service Modification
- ☐ Add a service
- ☐ Increasing level/hours of service
- ☐ Decreasing level/hours of service
- ☐ Provider Modification (requires 2 ISARs)
- ☐ End a service

MR Waiver
Consumer-Directed Personal Assistance
Individual Service Authorization Request

CSB _____

CSB provider # _____

Name: _____ Medicaid No. _____

Last, First MI

Services Facilitator (SF) _____ Provider No. _____ SF Start Date _____ Reassessment? Y__ N__

SF agency, if applicable _____ CD Assistant _____

Will the individual be directing his or her own services? ☐ Yes ☐ No If NO, name and relationship of responsible family caregiver: _____

| SERVICE TO BE PROVIDED | WEEKLY / YEARLY HOURS | OMR USE ONLY |
|--|---|--------------|
| CD Personal Assistance – Y0078 Start Date _____ | _____ Hours / week x 52 = Yearly total (1) | |

Reason for this request: _____

Check the allowable activities included in the individual's ISP. Indicate the *total* number of hours per day of CD PA.

| Assistance with | SUN | MON | TUE | WED | THUR | FRI | SAT |
|--|-----|-----|-----|-----|------|-----|-----|
| <input type="checkbox"/> activities of daily living (<i>Must need to receive PA</i>) <input type="checkbox"/> monitoring health status & physical condition <input type="checkbox"/> self-medication and/or other medical needs <input type="checkbox"/> meal preparation and eating <input type="checkbox"/> housekeeping activities <input type="checkbox"/> participating in recreational activities <input type="checkbox"/> appointments or meetings <input type="checkbox"/> bowel/bladder programs, range of motion exercises, routine wound care (per MD's orders and RN oversight) <input type="checkbox"/> general support to assure safety <input type="checkbox"/> activities in the workplace (does not duplicate services at the worksite) | | | | | | | |
| <u>Training for assistant</u> <input type="checkbox"/> as requested by the individual or caregiver that relates to services described in the ISP | | | | | | | |
| Comments: _____ | | | | | | | |

Signature of Facilitator _____ Date _____

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print) _____ Phone No. _____ Fax No. _____

Signature _____ Date _____

- ☐ Initiate Waiver services
- ☐ Service Modification
- ☐ Add a service
- ☐ Increasing level/hours of service
- ☐ Decreasing level/hours of service
- ☐ Provider Modification (requires 2 ISARs)
- ☐ End a service

MR Waiver
Consumer-Directed Respite
Individual Service Authorization Request

CSB _____

CSB provider # _____

Name: _____ Medicaid No. _____

Last, First MI

Services Facilitator (SF) _____ Provider No. _____ SF Start Date _____ Reassessment? Y__ N__

SF agency, if applicable _____ CD Assistant _____

Will the individual be directing his or her own services? ☐ Yes ☐ No If NO, name and relationship of responsible family caregiver: _____

| SERVICE TO BE PROVIDED | HOURS NEEDED | OMR USE ONLY |
|--------------------------------|--------------|--------------|
| CD Respite Start Date _____ | | |

Reason for this request: _____

Check the allowable activities included in the individual's ISP. Indicate the *total* number of hours per day of CD Respite, not to exceed 720 hours per calendar year (including agency-directed).

| Assistance with | SUN | MON | TUE | WED | THUR | FRI | SAT |
|--|-----|-----|-----|-----|------|-----|-----|
| <input type="checkbox"/> activities of daily living <input type="checkbox"/> monitoring health status & physical condition <input type="checkbox"/> self-medication and/or other medical needs <input type="checkbox"/> meal preparation and eating <input type="checkbox"/> housekeeping activities <input type="checkbox"/> participating in recreational activities <input type="checkbox"/> appointments or meetings <input type="checkbox"/> bowel/bladder programs, range of motion exercises, routine wound care (per MD's orders and RN oversight) <input type="checkbox"/> general support to assure safety | | | | | | | |
| <u>Training for assistant</u> <input type="checkbox"/> as requested by the individual or caregiver that relates to services described in the ISP | | | | | | | |
| Comments: _____ | | | | | | | |
| List any current or previously authorized Respite providers and hours since January of this year: _____ | | | | | | | |

Signature of Facilitator _____ Date _____

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print) _____ Phone No. _____ Fax No. _____

Signature _____ Date _____

- ☐ Initiate Waiver services
☐ Service Modification
 ☐ Add a service
 ☐ Increasing level/hours of service
 ☐ Decreasing level/hours of service
☐ Provider Modification (requires 2 ISARs)
☐ End a service

MR Waiver
Personal Emergency Response System
Individual Service Authorization Request

CSB _____

CSB provider # _____

| | | | | |
|------------------|-------|----|-----------------|------|
| Provider Name | | | Provider Number | |
| Name: | | | Start: | End: |
| Last, | First | MI | Date | Date |
| Medicaid Number: | | | | |

| CHECK SERVICE TO BE PROVIDED | UNITS | OMR USE ONLY |
|--|-------|--------------|
| <input type="checkbox"/> Y0071 Personal Emergency Response System Installation | | |
| <input type="checkbox"/> Y0072 PERS & Medication Monitoring Installation | | |
| <input type="checkbox"/> Y0073 PERS Monitoring | | |
| <input type="checkbox"/> Y0074 PERS & Medication Monitoring | | |
| <input type="checkbox"/> Y0075 PERS Nursing RN (to fill Med Monitoring Unit) | | |
| <input type="checkbox"/> Y0076 PERS Nursing LPN (to fill Med Monitoring Unit) | | |
| | | |

| |
|--|
| Reason for this request (To qualify, no one else competent in home or continuously available to call for help) |
| |
| |
| Check the following regarding the PERS: <input type="checkbox"/> Individual lives alone and has no regular caregiver for extended periods of time. <input type="checkbox"/> Individual is alone for significant parts of the day and has no regular caregiver for extended periods of time. <input type="checkbox"/> Individual requires extensive routine supervision. <input type="checkbox"/> Individual requires Medication Monitoring Unit; date of physician's order is _____. |
| Comments: |

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

| | | | | |
|------------------------------|-----------|-----------|---------|------|
| CSB Rep/Case Manager (print) | Signature | Phone No. | Fax No. | Date |
|------------------------------|-----------|-----------|---------|------|

- ☐ Initiate Waiver services
- ☐ Service Modification
- ☐ Add a service
- ☐ Increasing level/hours of service
- ☐ Decreasing level/hours of service
- ☐ Provider Modification (requires 2 ISARs)
- ☐ End a service

MR Waiver Prevocational Services Individual Service Authorization Request

CSB _____

CSB provider # _____

Provider Name _____

Provider No. _____

Name: _____

ISP Start: _____

ISP End: _____

Last,

First

MI

Date

Date

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED

WEEKLY / YEARLY UNITS

OMR USE ONLY

| | | | | |
|---|--------------|--------|--------------|--|
| <input type="checkbox"/> PREVOC Prevocational, Reg Int. Center Based | | | | |
| <input type="checkbox"/> PREVOC Prevocational, High Int. Center Based | | | | |
| <input type="checkbox"/> PREVOC Prevocational, Reg Int. Non Center Based | | | | |
| <input type="checkbox"/> PREVOC Prevocational, High Int. Non Center Based | Units / week | x 52 = | Yearly total | |

Reason for this request: _____

If High Intensity, check which criteria are met:

- ☐ Requires physical assistance to meet basic personal care needs
- ☐ Has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals

☐ Requires extensive personal care and/or constant supports to reduce or eliminate behaviors which preclude full participation in programming. [A formal written behavioral program or behavioral objective is required to address behaviors such as self-injury or self-stimulation.]

Check the allowable activities that are included in the individual's plan:

Training & support

- ☐ in skills aimed at preparation for paid employment offered in a variety of community settings
- ☐ in activities primarily directed at rehabilitative goals (e.g., attention span and motor skills)
- ☐ that is focused on completing assignments, solving problems or safety

Assistance & supervision

- ☐ with personal care
- ☐ to ensure the individual's health and safety

Travel

- ☐ with the individual to and from work sites, when other travel assistance unavailable

There is documentation in the record that Prevocational Services cannot be obtained from the school system (for those less than 22 years) nor from Department of Rehabilitative Services? ☐ Yes ☐ No

| Record the number of hours per day of the following: (for biweekly/varied schedules, draw a line to indicate different weeks) | SUN | MON | TUES | WED | THU | FRI | SAT |
|--|-----|-----|------|-----|-----|-----|-----|
| TOTAL HOURS OF PROGRAM TIME (e.g., if individual is in program from 8 a.m. until noon, enter "4") | | | | | | | |
| Travel with the individual to & from program: [record if billing for this time; can be included up to 25% of the total time; to bill for a 3-unit day, a minimum of 7 hrs of other allowable activities is required; does not include training related travel in scheduled activities] | | | | | | | |

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

Name of Provider Agency Representative (print) _____

Signature _____

Date _____

I agree that the above plan of services is appropriate to the identified needs of this individual. This service modification has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/Case Manager (print) _____

Signature _____

Phone No. _____

Fax No. _____

Date _____

Mental Retardation Community Medicaid Services

INDIVIDUAL SERVICE PLAN

MR Case Management - 90 DAY ASSESSMENT Z8545

Consumer: _____ Medicaid Number: _____

CSB: _____ Provider Number: _____

Case Manager: _____ Telephone: _____

Start Date: _____ End Date: _____ Quarterly Review Dates: N/A

| CASE MANAGEMENT OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES |
|--|-------------|--|
| <p>1) Determine diagnostic eligibility.</p> <p>IF DIAGNOSTICALLY ELIGIBLE, CONTINUE. IF NOT, COMPLETE TERMINATION SAR.</p> <p>2) Determine the need for active Case Management.</p> <p>3) Coordinate the assessment of consumer's current situation and strengths in major life areas, and determine service and supports needed within the community.</p> <p>4) Complete required documentation and maintain in consumer CM record.</p> | | <p>Complete SAR for 90 day case management and forward to Pre-Authorization Specialist. Start date is the date of the first face-to-face meeting.</p> <p>Review financial situation and assist consumer in applying for SSI and Medicaid, if applicable.</p> <p>Obtain supporting documentation from other Sources: medical, psychological, development assessment, etc.</p> <p>Meet with consumer (and parents when appropriate) to discuss and review supports and needs.</p> <p>Determine with consumer/parent(s) if the frequency and level of case management supports require a monthly activity.</p> <p>Complete Consumer Profile/Social Assessment. Assure preferences and interests are included.</p> <p>Complete other formal/informal assessments needed to determine any other case management needs.</p> <p>Meet with consumer/parent(s) to review results of assessments, set personal goals, and identify supports needed.</p> <p>Complete per contact case documentation and monthly activity(s).</p> <p>If eligible, forward SAR to Pre-Authorization Specialist for on-going SPO-CM. If ineligible, complete SAR terminating services.</p> |

Mental Retardation Community Medicaid Services

 NEW
FOR CSP YEAR

 REVISION
FOR CSP YEAR

INDIVIDUAL SERVICE PLAN**MR Case Management Z8545**

Consumer: _____ Medicaid Number: _____

CSB: _____ Provider Number: _____

Case Manager: _____ Telephone: _____

Start Date: _____ End Date: _____ Quarterly Review Dates: _____ / _____ / _____

| CASE MANAGEMENT OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES |
|---|-------------|--|
| 1) Coordinate the comprehensive assessment of the strengths and needs of consumer in major life areas and identify supports and services needed in the community. | | Complete Consumer Profile/Social Assessment. Coordinate, at least annually, the completion or update of relevant assessments. Involve support providers and significant others in gathering assessment information. |
| 2) Coordinate the completion of the Consumer Service Plan. | | Distribute copies of SAR to providers and billing staff. |
| 3) Link the consumer with appropriate community resources and supports, and coordinate with personnel of other agencies. | | Complete any needed referrals for newly identified services and complete termination of services no longer desired by the consumer. Obtain needed authorizations/approvals for funding of services from identified agencies. |
| 4) Coordinate the implementation of the Consumer Services Plan. | | Assist in the development of and review all Individual Service Plans (ISPs) from providers selected by the consumer. |
| 5) Monitor all services and on-going services to ensure the identified supports being delivered meet the needs and satisfaction of the individual and revise CSP as needed. | | Complete at least one activity monthly with/for the consumer, i.e., phone calls, correspondence, visits, etc. to ensure/obtain needed supports (as related to the assessment). At least quarterly (90 days), meet and review with consumer/significant others, supports being provided; satisfaction with services; and to identify any changes or additions requested by the consumer. |
| 6) Complete required documentation and maintain in consumer CM record. (NOT A BILLABLE ACTIVITY, IN AND OF ITSELF) | | Complete at least monthly case documentation of activities; quarterly reviews of services provided, documentation of visits/meetings with the consumer, and collateral contacts. |

Consumer: _____ Service: _____ Date: _____

| CASE MANAGEMENT OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES |
|----------------------------|----------------|------------------------|
| | | |

Mental Retardation Community Medicaid Services

INDIVIDUAL SERVICE PLAN

60 DAY ASSESSMENT

Indicate Service: _____ Residential Support _____ Supported Employment
 _____ Day Support _____ Personal Assistance

ESTIMATED DURATION: **NOT TO EXCEED 60 DAYS**

Consumer: _____ Medicaid Number: _____

Code: _____ Provider Name: _____ Provider Number: _____

Responsible Person: _____ Telephone: _____

Start Date: _____ End Date: _____ Quarterly Review Dates: _____

| CSP SELECTED GOAL/ DESIRED OUTCOME: To develop an ongoing plan of training and supports that will best address the consumer's interests and personal goals for living in the community. | | |
|--|-------------|--|
| OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES (T: Training, A: Assistance, S: Specialized Supervision) |
| 1) _____ will participate in an assessment of his/her abilities, strengths, interests and areas in which assistance and/or training is needed. The following areas (allowable for the above checked service) will be assessed: | | Staff will evaluate all areas indicated and complete the required documentation of observations and assessments. Staff will identify personal preferences that work/do not work for this consumer. Frequency: Staff will assess and document the need for overnight supervision (if applicable). Frequency: |
| 2) _____ will receive any needed assistance in the following areas (allowable for the above checked services): | | Staff will provide needed assistance and specialized supervision (if applicable) with activities pertinent to this service throughout the assessment period. Frequency: |
| 3) _____ will participate in an orientation to the service site(s) and agency/situational procedures regarding fires and other emergencies | | Staff will orient this consumer to the applicable service site(s) and emergency procedures. Frequency: |

Consumer: _____ Service: _____ Start Date: _____

| CSP SELECTED GOAL/ DESIRED OUTCOME: To develop an ongoing plan of training and supports that will best address the consumer's interests and personal goals for living in the community. | | |
|---|-------------|--|
| OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES (T: Training, A: Assistance, S: Specialized Supervision) |
| 4) _____ will receive needed assistance/supervision for the following known health/safety issue(s): | | <p>Staff will perform the following procedures to assist this consumer with his/her health/safety issue(s):</p> <p>Frequency:</p> |
| 5) _____ will receive needed assistance/supervision for the following known behavioral issue(s): | | <p>Staff will perform the following procedures to assist this consumer with his/her behavioral issue(s) :</p> <p>Frequency:</p> |
| 6) _____ will participate in the development of a written, person-centered ISP that includes strategies that will best support the achievement of his/her goals as identified on the CSP. | | <p>Staff will develop, with assistance from this consumer, the case manager, and family members, specific objectives, activities and strategies that correspond to the selected goals on the CSP and match the consumer's desires, interests and support needs.</p> <p>Frequency:</p> |

Consumer: _____ Service: _____ Start Date: _____

| | | |
|-------------------------------------|----------------|--|
| CSP SELECTED GOAL/ DESIRED OUTCOME: | | |
| OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES (T: Training, A: Assistance, S: Specialized Supervision) |
| | | |

| | | |
|-------------------------------------|----------------|--|
| CSP SELECTED GOAL/ DESIRED OUTCOME: | | |
| OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES (T: Training, A: Assistance, S: Specialized Supervision) |
| | | |

OPTIONAL

Consumer: _____ Service: _____ Start Date: _____

TOTAL HOURS/ UNITS PER WEEK_____

GENERAL SCHEDULE OF SERVICES

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|--------|---------|-----------|----------|--------|----------|--------|
| | | | | | | |

COMMENTS:
(Role of other agencies if plan is a shared responsibility)

Mental Retardation Community Medicaid Services

_____**NEW**
FOR CSP YEAR

_____**REVISION**
FOR CSP YEAR

INDIVIDUAL SERVICE PLAN

Indicate Service: _____ Personal Assistance Services
XXXX **Respite Care**

ESTIMATED DURATION: _____

Consumer: _____ Medicaid Number: _____

Code: **Z9421** Provider Name: _____ Provider Number: _____

Responsible Person: _____ Telephone: _____

Start Date : _____ End Date: _____ Quarterly Review Dates: _____ / _____ / _____ / _____ / _____

CSP SELECTED GOAL/ DESIRED OUTCOME: To provide temporary care to consumer normally provided by family or primary care giver.

| OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES (A: Assistance, G: General Supervision) |
|---|-------------|--|
| 1) Assist the consumer with personal care and daily activities. | | <p>Staff will provide assistance in the following areas (Specify):</p> <p>Personal Care: _____ Frequency: _____</p> <p>Monitoring Health/Physical Condition : _____ Frequency: _____</p> <p>Medication/Other Medical Needs : _____ Frequency: _____</p> <p>Meal Preparation: _____ Frequency: _____</p> <p>Housekeeping: _____ Frequency: _____</p> <p>Accompanying to Meetings and/or Appointments: _____ Frequency: _____</p> <p>Participation in Recreational Activities: _____ Frequency: _____</p> <p>Other: _____</p> |
| 2) Ensure the health and safety of the consumer. | | <p>Staff will provide supervision in the following areas (Specify):</p> <p>Personal Care: _____ Frequency: _____</p> <p>Monitoring Health/Physical Condition: _____ Frequency: _____</p> <p>Medication/Other Medical Needs: _____ Frequency: _____</p> <p>Meal Preparation: _____ Frequency: _____</p> <p>Housekeeping: _____ Frequency: _____</p> <p>Supervision to Insure Safety: _____ Frequency: _____</p> <p>Participation in Recreational Activities: _____ Frequency: _____</p> <p>Other: _____</p> |

Consumer: _____ Service: **Respite Care** Start Date: _____

| CSP SELECTED GOAL/ DESIRED OUTCOME: To provide temporary care to consumer normally provided by family or primary care giver. | | |
|---|-------------|--|
| OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES (A: Assistance, G: General Supervision) |
| <p>3) Complete documentation a minimum of monthly on services provided in support plan.</p> <p>4) Recommend to CSB CM modifications to ISP as needed, to ensure completion of stated objectives.</p> <p>5) Inform Case Manager of respite supports provided during the quarter.</p> | | <p>Documentation will include the following:</p> <ul style="list-style-type: none"> - date/supports provided; - total amount of time (in and out) of service delivery. - signature of persons providing the support. - consumer's responses and satisfaction with the service provided. (Can use DMAS 90 Aide form). <p>Forward to CSB CM as requested no later than _____ working days following the end of the month for which the service is delivered.</p> <p>Advise CM on the monthly note, if services were not delivered as scheduled.</p> <p>Forward revised ISP to CM for approval PRIOR to implementation.</p> <p>Complete written OR verbal summary of supports delivered during the quarter and forward to or advise the CSB CM as requested, no later than _____ working days following the end of the quarter (unless otherwise required by licensing or certification).</p> |

OPTIONAL FORM

Consumer: _____ Service: **Respite Care** Start Date: _____

TOTAL HOURS PER YEAR

GENERAL SCHEDULE OF SERVICES

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|--------|---------|-----------|----------|--------|----------|--------|
| | | | | | | |

NOTE: Respite Services are limited to 720 hours per calendar year.

COMMENTS:

Mental Retardation Community Medicaid Services

 NEW
FOR CSP YEAR

 REVISION
FOR CSP YEAR

INDIVIDUAL SERVICE PLAN

Indicate Service: **XXX Personal Assistance Services** _____ Respite Care ESTIMATED DURATION _____

Consumer: _____ Medicaid Number _____

Code: **Z4036** _____ Provider Name: _____ Provider Number: _____

Responsible Person: _____ Telephone: _____

Start Date: _____ End Date: _____ Quarterly Review Dates: _____

CSP SELECTED GOAL/ DESIRED OUTCOME: To receive needed assistance and supervision with personal care and daily activities to live in the community.

| OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES (A: Assistance, G: General Supervision) |
|---|-------------|--|
| 1) Assist the consumer with personal care and a variety of daily activities. Note: Activities of Daily Living (ADLs) can not total more than 5 hr daily. | | Staff will provide assistance in the following areas (Specify): Personal Care: _____ Frequency: _____ Monitoring Health/Physical Condition : _____ Frequency: _____ Medication/Other Medical Needs _____ Frequency: _____ Meal Preparation: _____ Frequency: _____ Housekeeping: _____ Frequency: _____ Accompanying to Meetings and/or Appointments: _____ Frequency: _____ Participation in Recreational Activities: _____ Frequency: _____ Other: _____ |
| 2) Assure the consumer's ongoing health and safety. Note: General Supervision hours can not total more than 8 hrs daily. | | Staff will provide supervision in the following areas (Specify): Personal Care: _____ Frequency: _____ Monitoring Health/Physical Condition : _____ Frequency: _____ Medication/Other Medical Needs: _____ Frequency: _____ Meal Preparation: _____ Frequency: _____ Housekeeping: _____ Frequency: _____ Supervision to Insure Safety: _____ Frequency: _____ Participation in Recreational Activities: _____ Frequency: _____ Other: _____ |

Consumer: _____ Service: Personal Assistance Start Date: _____

| CSP SELECTED GOAL/ DESIRED OUTCOME: To receive needed assistance and supervision with personal care and daily activities to live in the community. | | |
|---|-------------|---|
| OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES (A: Assistance, G: General Supervision) |
| <p>3) Complete documentation a minimum of monthly on services provided in support plan.</p> <p>4) Recommend to CSB CM modifications to ISP as needed, to ensure completion of stated objectives.</p> <p>5) Complete quarterly reviews (summaries of services provided and consumer's response).</p> <p>ADL hours: _____ Supervision Hours: _____</p> <p>TOTAL HRS PER WEEK: _____</p> | | <p>Documentation will include the following:</p> <ul style="list-style-type: none"> -date/supports provided; -total amount of time (in and out) of service delivery. -signature of persons providing the support. -consumer's responses and satisfaction with the service provided. (Can use DMAS 90 Aide form). <p>Forward to CSB CM as requested no later than _____ working days following the end of the month for which the service is delivered.</p> <p>Advise CM on the monthly note, if services were not delivered as scheduled.</p> <p>Forward revised ISP to CM for approval PRIOR to implementation.</p> <p>Forward to CSB CM as requested no later than _____ working days following the end of the quarter.</p> |

Consumer: _____ Service: **Personal Assistance** Start Date: _____

TOTAL HOURS PER WEEK: _____

GENERAL SCHEDULE OF SERVICES

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|--------|---------|-----------|----------|--------|----------|--------|
| | | | | | | |

COMMENTS:
(Role of other agencies if plan a shared responsibility)

**INDIVIDUAL SERVICE PLAN
THERAPEUTIC CONSULTATION**

Z8565

Indicate Type: ____ OT ____ PT ____ Speech ____ Recreation ____ Psychology ____ Behavior ____ RehEng ____

Consumer _____ Medicaid Number _____

Provider Name: _____ Provider Number: _____

Responsible Person: _____ Telephone: _____

Start Date: _____ End Date: _____ Quarterly Review Dates: _____

| CSP SELECTED GOAL/ DESIRED OUTCOME: | | |
|--|---|------------------------------|
| CONSULTATION OBJECTIVES | ACTIVITIES/STRATEGIES (TARGET AUDIENCE) | PROJECTED HOURS |
| 1) Complete a thorough assessment of the consumer and relevant environments per CSP goal/desired outcome. | 1a) Meet with Consumer and relevant others to confirm desired outcome of consultation and supports needed. b) Observe Consumer in various environments as needed (home, work, etc.) c) Review documentation from other programs and sources to determine types of supports needed and any previous supports and interventions attempted. d) Complete the following evaluations and/or assessments: _____ _____ | By: _____ #Hrs. _____ |
| 2) Collaborate with Consumer and relevant others to develop a written SUPPORT PLAN detailing the strategy/intervention to be implemented by staff and/or family. | 2a) Summarize assessment information and proposed strategies with Consumer, Case Manager and relevant others. b) Finalize the Consumer's SUPPORT PLAN and obtain agreement from Consumer, Case Manager and relevant others. Attach the SUPPORT PLAN, dated and signed by the Consultant, Consumer, and others, to this current Therapeutic Consultation Individual Service Plan. c) Develop a data collection system to be used by relevant others that evaluates the effectiveness of the SUPPORT PLAN (states frequency to collect data, what to record, etc.). d) Obtain confirmation from the appropriate CSB staff that the SUPPORT PLAN is in agreement with Human Rights regulations, policies, and procedures. | By: _____ #Hrs. _____ |

| CONSULTATION OBJECTIVES | ACTIVITIES/ STRATEGIES (TARGET AUDIENCE) | PROJECTED HOURS |
|---|---|--|
| 3) Provide guidance and complete hands-on training to providers/family members on the implementation of the SUPPORT PLAN. | <p>3a) Assist relevant others in making necessary environmental and program adjustments that may be interfering with the Consumer</p> <p>b) Identify location(s), schedule, and participants for the hands-on training.</p> <p>c) Teach relevant persons to</p> <ul style="list-style-type: none"> -Implement interventions/support techniques; -Observe and record data; and -Evaluate the effectiveness of the SUPPORT PLAN. | <p>Frequency: _____</p> <p>(mon., quarterly, weekly, etc.)</p> <p>_____ Hours per session</p> <p>By: _____</p> <p># Hrs. _____</p> |
| 4) Evaluate the effectiveness of the SUPPORT PLAN and make any needed adjustments. | <p>4a) Conduct on-site observations and interviews with Consumer and relevant others implementing the SUPPORT PLAN (work, home, etc.).</p> <p>b) Analyze the documentation of consumer's response to interventions and the data collection methodology.</p> <p>c) Confer with Case Manager about any recommended changes. Make changes in the SUPPORT PLAN strategies as needed. Forward changes to Case Manager prior to implementation.</p> | <p>By: _____</p> <p># Hrs: _____</p> |
| 5) Include supervisory staff of receiving agency in all aspect of the Consultation. | <p>5a) Coordinate schedule with supervisory staff;</p> <p>b) Provide staff with any written materials pertinent to the Consultation.</p> | |

| CONSULTATION OBJECTIVES | ACTIVITIES/ STRATEGIES (TARGET AUDIENCE) | PROJECTED HOURS |
|---|--|--|
| 6) Complete verbal and written communication related to the Therapeutic Consultation ISP. | 6a) Record contact notes for every billable activity. Forward a monthly note, if applicable, to the Case Manager within ____ calendar days following the end of the month. Summary includes: -Date/location and time of service delivery; -ISP objective addressed; -Specific details of the activity; -Services delivered as planned or modified; -Effectiveness of the strategies and Consumer's satisfaction with service. b) Complete quarterly reviews/summaries and forward to Case Manager within ____ calendar days following the end of the quarter. Summaries will include the activities related to the Therapeutic Consultation ISP, the effectiveness of the SUPPORT PLAN, and Consumer's satisfaction with the service. | Objective #6 is not a billable activity. |
| 7) Determine need for continuation or termination of services. | 7a) Confer with Consumer and relevant service providers to integrate the SUPPORT PLAN strategies into the INDIVIDUAL SERVICES PLAN(S) of applicable programs. b) Make recommendations to Case Manager for continuation or termination of Therapeutic Consultation service. | |

TOTAL HOURS FOR ISP _____
FROM ISP Pages 1-3

Initial ISP ____ Y ____ N

Mental Retardation Community Medicaid Services

INDIVIDUAL SERVICE PLAN - CRISIS STABILIZATION**Z8999 Clinical/Behavior Intervention** _____**Z8899 Crisis Supervision**

Consumer _____ Medicaid Number _____

Provider Name: _____ Provider Number: _____

Responsible Person: _____ Telephone: _____

Start Date: _____ End Date: _____

(Maximum 15 days per authorization; maximum limit - 60 days in a calendar year)

CSP SELECTED GOAL/ DESIRED OUTCOME: To provide direct interventions during a crisis to enable a consumer to remain in his/her community setting.

| OBJECTIVES | ACTIVITIES/STRATEGIES (TARGET AUDIENCE) | PROJECTED |
|--|---|---|
| <p>1) Prior to implementation of service, qmrp will complete a face-to-face assessment to determine clinical interventions needed. This assessment may be conducted jointly with a licensed mental health professional or other appropriate professionals.</p> <p>2. Determine that documentation is present to confirm eligibility for service.</p> <p>3. Determine that the consumer is at risk.</p> | <p>1a) Meet with Consumer face-to-face to confirm current situation and supports needed.</p> <p>b) Give estimated hours of needed intervention to Case Manager for completion of Service Authorization Request.</p> <p>CHECK ALL THAT APPLY:</p> <p>2) Case Manager or other appropriate personnel, review case notes to confirm that consumer:</p> <p>____ a) is experiencing marked reduction in psychiatric, adaptive, or behavioral functioning; OR</p> <p>____ b) is experiencing extreme increase in emotional distress; OR</p> <p>____ c) needs continuous intervention to maintain stability; OR</p> <p>____ d) is causing harm to self or others.</p> <p>CHECK ALL THAT APPLY:</p> <p>3) Case Manager or other appropriate personnel, review case notes, meet with consumer/significant others, to confirm that the consumer is at risk of</p> <p>____ a) psychiatric hospitalization; OR</p> <p>____ b) emergency ICF-MR placement; OR</p> <p>____ c) disruption of community status (living arrangement, day placement, or school; OR</p> <p>____ d) causing harm to self or others.</p> | NOT BILLABLE UNDER CRISIS STABILIZATION |

| OBJECTIVES | ACTIVITIES/ STRATEGIES (TARGET AUDIENCE) | PROJECTED HOURS |
|--|---|--------------------|
| 4. Staff qualified to provide crisis stabilization will provide activities to stabilize consumer in his/her community. | CHECK ALL THAT APPLY: 4) Meet with consumer and/or significant others in consumer's home, day support setting, respite setting, etc. in order to: <input type="checkbox"/> a) Complete a psychiatric, neuropsychiatric, or psychological assessment & and other functional assessments; OR <input type="checkbox"/> b) Review current medication schedule & need for any changes; OR <input type="checkbox"/> c) Complete/review behavior assessment and/or behavioral support plan; OR <input type="checkbox"/> d) Complete intense case coordination with other agencies/providers for delivery of supports that will enable consumer to remain in the community; OR <input type="checkbox"/> e) Complete training for family members/other caregivers/service providers in positive behavior supports to enable consumer to remain in the community. | |
| | | |
| | TOTAL hours for CLINICAL INTERVENTION | |
| IF APPLICABLE: 5. As a component of Crisis Stabilization, provide temporary crisis supervision to ensure the safety of the consumer & others. <u>(Restricted to staff of licensed Residential or Supportive Residential Services).</u> | 5. Supervise consumer, face-to-face, 1:1 to ensure the safety of consumer. | |
| | TOTAL NUMBER OF SUPERVISION HOURS | |
| NUMBER OF AUTHORIZED CRISIS STABILIZATION days year-to-date: _____ | | |

Mental Retardation Community Medicaid Services

_____**New**
for CSP Year

_____**Revision**
for CSP Year

INDIVIDUAL SERVICE PLAN

Indicate Service: _____Residential Support _____Supported Employment _____Day Support

Consumer: _____ Medicaid Number: _____

Code: _____ Provider Name: _____ Provider Number: _____

Responsible Person: _____ Telephone: _____

Start Date of Service: _____ Quarterly Review Dates: _____

CSP SELECTED GOAL/ DESIRED OUTCOME:

| OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES (Frequency) (T: Training, A: Assistance, S: Specialized Supervision) |
|------------|-------------|--|
| | | |

Consumer: _____ Service: _____ Date: _____

CSP SELECTED GOAL/ DESIRED OUTCOME:

Approximate hours per week:

| OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES (T: Training, A: Assistance, S: Specialized Supervision) |
|------------|----------------|--|
| | | |

CSP SELECTED GOAL/ DESIRED OUTCOME:

| OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES (T: Training, A: Assistance, S: Specialized Supervision) |
|------------|----------------|--|
| | | |

Consumer:_____Service:_____Date:_____

CSP SELECTED GOAL/ DESIRED OUTCOME:

| OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES (T: Training, A: Assistance, S: Specialized Supervision) |
|------------|----------------|--|
| | | |

Consumer:

Service:

Date: _____

TOTAL HOURS/ UNITS PER WEEK

GENERAL SCHEDULE OF SERVICES (If Appropriate)

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|--------|---------|-----------|----------|--------|----------|--------|
| | | | | | | |

COMMENTS:

Mental Retardation Community Medicaid Services**_____ New
for CSP Year****_____ Revision
for CSP Year****INDIVIDUAL SERVICE PLAN**

Indicate Service: _____ Environmental Modifications _____ Assistive Technology

Consumer: _____ Medicaid Number: _____

CSB: _____ CSB Provider Number: _____

Responsible Person: _____ Telephone: _____

Start Date of Service: _____ End Date: _____

CSP SELECTED GOAL/ DESIRED OUTCOME:

Attach copies of product and price information

Specific Environmental Modifications or Assistive Technology/ Name of Vendor:

Mental Retardation Community Medicaid Services

____ **NEW**
FOR CSP YEAR

____ **REVISION**
FOR CSP YEAR

CONSUMER-DIRECTED PERSONAL ASSISTANCE INDIVIDUAL SERVICE PLAN

ESTIMATED DURATION: _____ Quarterly Review Dates: _____

Individual: _____ Medicaid Number: _____

Services Facilitator/Agency: _____ SF Provider Number: _____

Services Facilitator Telephone Number: _____ Services Facilitation Start Date: _____

CD Assistant's Name: _____ CD Services Start Date: _____ End Date: _____

SUPPORT GOAL/ OUTCOME: *To be as independent as possible in my home and community*

| PURPOSE OF SUPPORT | WHEN SUPPORT IS PROVIDED | HOW AND WHERE SUPPORT WILL BE PROVIDED |
|---|---|--|
| <i>For example:</i> | | |
| 1. <i>To get ready for work</i> | <i>Work day mornings (M – F) from 7- 9 a.m.</i> | <i>In my home, my assistant will help me bathe and dress, prepare and eat breakfast, pack a lunch and catch the bus.</i> |
| 2. <i>To be involved in the community</i> | <i>Tues 6 - 9 pm; Sat 1 – 5 pm; Sun 10am – 1pm;</i> | <i>My assistant will help me schedule and accompany me to places and activities in the community, such as my bowling league, shopping, church, restaurants, visiting friends, and other activities that arise. He will help me with my personal needs, assist me in scheduling and using Medicaid Taxi, eating, and getting around safely.</i> |

| | | |
|----------------------------------|--|--|
| <p>TOTAL HRS PER WEEK: _____</p> | | |
|----------------------------------|--|--|

Mental Retardation Community Medicaid Services

 NEW
FOR CSP YEAR

 REVISION
FOR CSP YEAR

Consumer-Directed Respite Services INDIVIDUAL SERVICE PLAN

ESTIMATED DURATION: _____

Individual: _____ Medicaid Number: _____

Services Facilitator/Agency: _____ SF Provider Number: _____

Services Facilitator Telephone Number: _____ Services Facilitation Start Date: _____

CD Assistant's Name: _____ CD Services Start Date: _____ End Date: _____

SUPPORT GOAL/OUTCOME: To provide temporary care that is normally provided to this individual by the primary care giver.

| PURPOSE OF SUPPORT | WHEN SUPPORT IS PROVIDED | WHERE AND HOW SUPPORT WILL BE PROVIDED |
|--|---|--|
| For example: | | |
| 1) <i>To make sure I am safe while my parents are out; to help me with dinner and getting ready for bed</i> | <i>Every other Friday night 5 – 11</i> | <i>In my home, my assistant will help me prepare and eat dinner, keep me company while I unwind, get washed and dressed for bed and stay until my parents come home.</i> |
| 2) <i>To make sure I am safe while my parents are out; to help me with my laundry, lunch and a recreation activity</i> | <i>One Saturday/ month 10 am – 5 pm</i> | <i>In my home, my assistant will help me start my laundry, prepare and eat lunch, take my medications. My assistant will go with me to the park, the mall or some other place in the community. We will walk, if we can, to get exercise. My assistant will help me to be safe in the community.</i> |
| <p>TOTAL HRS PER YEAR: _____</p> | | |

NOTE: CD-Respite Care Services are limited to 720 hours per year (inclusive of any agency-directed Respite Care hours.)

Mental Retardation Community Medicaid Services

 NEW
FOR CSP YEAR

 REVISION
FOR CSP YEAR

Agency-Directed Companion Services INDIVIDUAL SERVICE PLAN

ESTIMATED DURATION: _____ Quarterly Review Dates: _____

Individual: _____ Medicaid Number: _____

Services Facilitator/Agency: _____ SF Provider Number: _____

Services Facilitator Telephone Number: _____ Services Facilitation Start Date: _____

CD Companion's Name: _____ CD Services Start Date: _____ End Date: _____

CSP SELECTED GOAL/ DESIRED OUTCOME: To provide non-medical care, socialization or supervision to this adult individual in the home or various locations in the community.

| OBJECTIVES | TARGET DATE | ACTIVITIES/ STRATEGIES Frequency = ____ X Day |
|--|----------------|--|
| 1) _____ will receive assistance with a variety of daily activities. | | <p>Staff will provide assistance or support in the following areas (Specify):</p> <p>Meal Preparation: _____</p> <p>_____</p> <p>Frequency: _____</p> <p>Laundry: _____</p> <p>_____</p> <p>Frequency: _____</p> <p>Light Housekeeping: _____</p> <p>_____</p> <p>Frequency: _____</p> <p>Shopping: _____</p> <p>_____</p> <p>Frequency: _____</p> <p>Community access and recreational activities:</p> <p>_____</p> <p>_____</p> <p>Frequency: _____</p> |

Individual: _____ Service: **AGENCY-DIRECTED COMPANION** Start Date: _____ 85

| | | |
|--|--|---|
| <p>2) _____'s ongoing health and safety will be assured.</p> | | <p>Other: _____</p> <p>_____</p> <p>Frequency:</p> <p>Staff will provide assistance in the following area (Specify):</p> <p>Reminder to take self-Administration of medication: _____</p> <p>_____</p> <p>Frequency:</p> <p>Staff will provide general support to assure safety:</p> <p>_____</p> <p>_____</p> <p>Frequency:</p> <p>Other: _____</p> <p>_____</p> <p>Frequency:</p> |
| <p>TOTAL HRS PER WEEK: _____</p> | | |

Individual: _____ Service: **AGENCY-DIRECTED COMPANION** Start Date: _____ 86

TOTAL HOURS PER WEEK

GENERAL SCHEDULE OF SERVICES

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|--------|---------|-----------|----------|--------|----------|--------|
| | | | | | | |

COMMENTS:

Mental Retardation Community Medicaid Services

NEW FOR
CSP YEAR

INDIVIDUAL SERVICE PLAN

REVISION FOR
CSP YEAR

Nursing Services

Consumer: _____ Medicaid Number: _____

Code: _____ Provider Name: _____ Provider Number: _____

Responsible Person: _____ Telephone: _____

Start Date: _____ End Date: _____ Quarterly Review Dates: _____

NURSING PROCEDURE(S) ORDERED BY PHYSICIAN

Physician's Name: _____ Physician's Signature: _____

NURSING PLAN

ACTIVITIES/ STRATEGIES

PROJECTED
HOURS

Consumer: _____ Service: _____ Date: _____

NURSING PLAN

| ACTIVITIES/ STRATEGIES | PROJECTED HOURS |
|------------------------|--------------------|
| | |

OPTIONAL FORM

Consumer: _____ Service _____ Start Date: _____

TOTAL HOURS PER WEEK _____

GENERAL SCHEDULE OF SERVICES

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|--------|---------|-----------|----------|--------|----------|--------|
| | | | | | | |

COMMENTS:
(Role of other agencies if plan a shared responsibility)

RECIPIENT NAME _____ MEDICAID ID# _____
 PROVIDER AGENCY _____ AGENCY ID# _____

✓ EACH TASK TO BE DONE, ENTER TIME NEEDED FOR EACH CATEGORY AND ADD FOR TOTAL TIME

| CATEGORIES/TASKS | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|-------------------------------|--------|---------|-----------|----------|--------|----------|--------|
| 1. ADL's | | | | | | | |
| Bathing | | | | | | | |
| Dressing | | | | | | | |
| Toileting | | | | | | | |
| Transfer | | | | | | | |
| Assist Eating | | | | | | | |
| Assist Ambulate | | | | | | | |
| Turn/Change Position | | | | | | | |
| TIME | | | | | | | |
| 2. SPECIAL MAINTENANCE | | | | | | | |
| Vital Signs | | | | | | | |
| Supervise Meds | | | | | | | |
| Range of Motion | | | | | | | |
| Wound Care | | | | | | | |
| Bowel/Bladder Program | | | | | | | |
| TIME | | | | | | | |
| 3. SUPERVISION | | | | | | | |
| TIME | | | | | | | |
| 4. HOUSEKEEPING | | | | | | | |
| Prepare Meals | | | | | | | |
| Clean Kitchen | | | | | | | |
| Make/Change Beds | | | | | | | |
| Clean Areas Used by Recipient | | | | | | | |
| Shop/List Supplies | | | | | | | |
| Laundry | | | | | | | |
| TIME | | | | | | | |
| TOTAL DAILY TIME | | | | | | | |

LEVEL OF CARE DETERMINATION FOR MAXIMUM WEEKLY HOURS

| | | | |
|--------------------------------------|---|--|---|
| BATHING SCORE | | TRANSFERRING SCORE | |
| Bathes without help/ w/MH only | 0 | Transfers without help/ w/MH only | 0 |
| Bathes w/HH or w/HH & MH | 1 | Transfers w/HH or w/HH & MH | 1 |
| Is bathed | 2 | Is transferred/ does not transfer | 2 |
| DRESSING | | EATING SCORE | |
| Dresses without help/ w/MH only | 0 | Eats without help/ w/MH only | 0 |
| Dresses w/HH or w/HH & MH | 1 | Eats w/ HH or HH & MH | 1 |
| Is dressed or does not dress | 2 | Is fed: spoon/tube/IV, etc. | 2 |
| AMBULATION SCORE | | CONTINENCY SCORE | |
| Walks/Wheels without help/ w/MH only | 0 | Continent/Incontinent < weekly/self care of internal/ external devices | 0 |
| Walks/Wheels w/HH or HH & MH | 1 | Incontinent weekly or >/Not self care | 2 |
| Totally Dependent for mobility | 2 | | |

LEVEL OF CARE SCORE= ____ A (Score 0-6) ____ B (Score 7-12) ____ C (Score 9+ Wounds, Tube Feedings, Etc.)
 LOC A=MAXIMUM HOURS 25/WK LOC B=MAXIMUM HOURS 30/WK LOC C=MAXIMUM HOURS 35/WK

REASON PLAN OF CARE SUBMITTED: ____ NEW ADMISSION ____ ↓ IN HOURS ____ ↑ IN HOURS ____ TRANSFER
 Reason For Change/Additional Instructions For The Aide: _____

Plan Of Care Effective Date _____ Total Weekly Hours _____ Rn Signature _____

PROVIDER NOTIFICATION TO CLIENT

This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, you may contact the RN Supervisor who has signed the plan of care to discuss the reason you disagree with the change.

If the person you contact is unwilling or unable to change the information you disagree with, you have the right to request reconsideration by notifying, in writing, the Community-Based Care Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219. This written request for reconsideration must be filed within thirty (30) days of the time you receive this notification. If you file a request for reconsideration before the effective date of this action, _____ services may continue unchanged during the reconsideration process. (effective date)

DMAS NOTIFICATION TO CLIENT

The provider submitted this Plan of Care to the Department of Medical Assistance Services (DMAS) to request approval of the changes noted. DMAS has _____ this request.

If you disagree with the DMAS decision, you have the right to appeal by notifying, in writing, the Division of Client Appeals, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219. This written request for appeal must be filed within thirty (30) days of the time you receive this notification. If you file a request for appeal before the effective date of this action, _____ services may continue unchanged during the reconsideration process. (effective date)

Analyst Signature and Date

Instructions for Completion of the DMAS-97-A

LEVEL OF CARE DETERMINATION FOR MAXIMUM WEEKLY HOURS

Enter a score for Each activity of daily living (ADL) based on the client's current functioning. Sum Each ADL Rating & Enter The Composite Score Under The Appropriate Category: A, B or C. **The amount of time allocated under TOTAL DAILY TIME to complete all tasks Must Not Exceed the maximum weekly hours for the specified LOC.**

PROVIDER NOTIFICATION TO CLIENT

Anytime the RN Supervisor changes the plan of care which results in a change in the total number of weekly hours, the RN must complete the entire front section of this form. If the change the agency is making does not require DMAS approval, the RN Supervisor is required to enter the effective date on the Provider Agency Client Notification Section which gives the client their right to reconsideration and make sure the client gets a copy of both the front and back of the form.

DMAS NOTIFICATION TO CLIENT

If the changes to the care plan require DMAS approval, the entire front portion of this form must be completed and forwarded to the agency's assigned analyst for approval. If supervision is requested, please remember to attach the Request for Supervision form (DMAS 100). Once received by DMAS, the assigned analyst will review the care plan and indicate whether the request is approved or denied. Once the decision is made, this form will be sent back to the provider agency who is responsible for making sure the client receives a copy of the back of this form (as well as the front) which gives the client's right to appeal.

AIDE RECORD

RECIPIENT NAME: _____ ADDRESS/PHONE: _____

| DAY | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|-------------------------------|--------|---------|-----------|----------|--------|----------|--------|
| DATE (Month/Day/Year) | | | | | | | |
| ACTIVITY: | | | | | | | |
| Complete/Partial Bath | | | | | | | |
| Dress/Undress | | | | | | | |
| Assist with Toileting | | | | | | | |
| Transferring | | | | | | | |
| Personal Grooming | | | | | | | |
| Assist with Eat-Feed | | | | | | | |
| Ambulation | | | | | | | |
| Turn/Change Position | | | | | | | |
| Vital Signs | | | | | | | |
| Assist with Self-Admin. | | | | | | | |
| Medication | | | | | | | |
| Bowel/Bladder | | | | | | | |
| Wound Care | | | | | | | |
| ROM | | | | | | | |
| Supervision | | | | | | | |
| Prepare Breakfast | | | | | | | |
| Prepare Lunch | | | | | | | |
| Prepare Dinner | | | | | | | |
| Clean Kitchen | | | | | | | |
| Wash Dishes | | | | | | | |
| Make/Change Bed Linen | | | | | | | |
| Clean Areas Used by Recipient | | | | | | | |
| Listing Supplies/ Shopping | | | | | | | |
| Recipient's Laundry | | | | | | | |
| TIME IN | | | | | | | |
| TIME OUT | | | | | | | |
| NUMBER OF HOURS | | | | | | | |

WEEKLY COMMENTS: DATE: _____

WEEKLY SIGNATURES:

| | | | |
|----------------------------|------|----------------|------|
| RECIPIENT/FAMILY SIGNATURE | DATE | AIDE SIGNATURE | DATE |
| <hr/> | | | |
| SUBSTITUTE AIDE | DATE | RN SIGNATURE | DATE |
| <hr/> | | | |

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

| | | | | | |
|--|---------------------------------------|--|---|---|--|
| 1. Patient's HI Claim No. | 2. Start Of Care Date | 3. Certification Period From: To: | | 4. Medical Record No. | 5. Provider No. |
| 6. Patient's Name and Address | | | 7. Provider's Name, Address and Telephone Number | | |
| 8. Date of Birth | | 9. Sex | <input type="checkbox"/> M <input type="checkbox"/> F | 10. Medications: Dose/Frequency/Route (N)ew (C)hanged | |
| 11. ICD-9-CM | Principal Diagnosis | Date | | | |
| 12. ICD-9-CM | Surgical Procedure | Date | | | |
| 13. ICD-9-CM | Other Pertinent Diagnoses | Date | | | |
| 14. DME and Supplies | | | 15. Safety Measures: | | |
| 16. Nutritional Req. | | | 17. Allergies: | | |
| 18.A. Functional Limitations | | | 18.B. Activities Permitted | | |
| 1 <input type="checkbox"/> Amputation | 5 <input type="checkbox"/> Paralysis | 9 <input type="checkbox"/> Legally Blind | 1 <input type="checkbox"/> Complete Bedrest | 6 <input type="checkbox"/> Partial Weight Bearing | A <input type="checkbox"/> Wheelchair |
| 2 <input type="checkbox"/> Bowel/Bladder (Incontinence) | 6 <input type="checkbox"/> Endurance | A <input type="checkbox"/> Dyspnea With Minimal Exertion | 2 <input type="checkbox"/> Bedrest BRP | 7 <input type="checkbox"/> Independent At Home | B <input type="checkbox"/> Walker |
| 3 <input type="checkbox"/> Contracture | 7 <input type="checkbox"/> Ambulation | B <input type="checkbox"/> Other (Specify) | 3 <input type="checkbox"/> Up As Tolerated | 8 <input type="checkbox"/> Crutches | C <input type="checkbox"/> No Restrictions |
| 4 <input type="checkbox"/> Hearing | 8 <input type="checkbox"/> Speech | | 4 <input type="checkbox"/> Transfer Bed/Chair | 9 <input type="checkbox"/> Cane | D <input type="checkbox"/> Other (Specify) |
| | | | 5 <input type="checkbox"/> Exercises Prescribed | | |
| 19. Mental Status: | | | 1 <input type="checkbox"/> Oriented | 3 <input type="checkbox"/> Forgetful | 5 <input type="checkbox"/> Disoriented |
| | 2 <input type="checkbox"/> Comatose | 4 <input type="checkbox"/> Depressed | 6 <input type="checkbox"/> Lethargic | 7 <input type="checkbox"/> Agitated | 8 <input type="checkbox"/> Other |
| 20. Prognosis: | | | 1 <input type="checkbox"/> Poor | 2 <input type="checkbox"/> Guarded | 3 <input type="checkbox"/> Fair |
| | | | 4 <input type="checkbox"/> Good | 5 <input type="checkbox"/> Excellent | |
| 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) | | | | | |
| 22. Goals/Rehabilitation Potential/Discharge Plans | | | | | |
| 23. Nurse's Signature and Date of Verbal SOC Where Applicable: | | | 25. Date HHA Received Signed POT | | |
| 24. Physician's Name and Address | | | 26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan. | | |
| 27. Attending Physician's Signature and Date Signed | | | 28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws. | | |

Form CMS-485 (C-3) (02-94) (Formerly HCFA-485) (Print Aligned)

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0367

ADDENDUM TO:☐**PLAN OF TREATMENT**☐**MEDICAL UPDATE**

1. Patient's HI Claim No.

2. SOC Date

3. Certification Period

4. Medical Record No.

5. Provider No.

From:

To:

6. Patient's Name

7. Provider Name

8. Item
No.

9. Signature of Physician

10. Date

11. Optional Name/Signature of Nurse/Therapist

12. Date

AGENCY LETTERHEAD

Sample A
Page 1 of 2

_____ (Date)

_____ (Consumer's name/address)

RIGHT TO APPEAL/NOTIFICATION LETTER

This letter is to inform you of a

☐ Termination ☐ Suspension ☐ Decrease ☐ Denial of a Request for an Increase in Services

for the following Mental Retardation (MR) Community Medicaid Service(s)

Check all that apply:**A. STATE PLAN OPTION SERVICE**

☐ Case Management

B. MR WAIVER SERVICE(S)

- | | |
|---|---|
| <input type="checkbox"/> Residential Support | <input type="checkbox"/> Environmental Modification |
| <input type="checkbox"/> Day Support/Supported Employment | <input type="checkbox"/> Assistive Technology |
| <input type="checkbox"/> Personal Assistance | <input type="checkbox"/> Crisis Stabilization |
| <input type="checkbox"/> Respite Services | <input type="checkbox"/> Therapeutic Consultation: (list) |
| <input type="checkbox"/> Nursing Services | |

The projected date for this action is: _____ .

 Right to Appeal/Notification letter
 Page 2
 _____ (Date)

Sample A
Page 2 of 2

This action was based on the following reason(s) (include regulatory guidelines):

If you are not in agreement with the above-stated action(s), you may appeal this decision by notifying, IN WRITING, within thirty (30) days of receipt of this letter:

APPEALS DIVISION
 Department of Medical Assistance Services (DMAS)
 600 E. Broad Street, Suite 1300
 Richmond, VA 23219

If this is a termination or reduction in services and if you file an appeal before the effective date of this action, _____ (date), services may continue during the appeal process. However, if this decision is upheld by the Appeals Division, you may be required to reimburse the Medical Assistance Program for the waiver services provided after _____(date).

This agency is required to inform you of your right to appeal, based upon State and Federal codes. (12 VAC [Virginia Administrative Code] 30-110-70 through 12 VAC 30-110-90) and Federal regulations (42 CFR [Code of Federal Regulations] 431).

If you have any questions regarding the actions noted in this letter, you may contact your Case Manager _____ by calling _____

or writing: _____

{ **Signature** }

AGENCY LETTERHEAD

Sample B
Page 1 of 2

_____ (Date)

_____ (Consumer's name/address)

RIGHT TO APPEAL/NOTIFICATION LETTER - DENIAL

This letter is to inform you that your request for following Mental Retardation Community Medicaid Service(s)

Check all that apply:

A. State Plan Option Service

☐ Case Management

B. Mental Retardation Waiver Community-based SERVICE(S)

- | | |
|---|---|
| <input type="checkbox"/> Residential Support | <input type="checkbox"/> Environmental Modification |
| <input type="checkbox"/> Day Support | <input type="checkbox"/> Assistive Technology |
| <input type="checkbox"/> Supported Employment | <input type="checkbox"/> Crisis Stabilization |
| <input type="checkbox"/> Personal Assistance | <input type="checkbox"/> Therapeutic Consultation: list |
| <input type="checkbox"/> Respite Services | |
| <input type="checkbox"/> Nursing Services | |

HAS BEEN DENIED for the following reason (include regulatory guidelines):

Right to Appeal/Notification letter- DENIAL
Page 2

Sample B
Page 2 of 2

_____ (Date)

If you are not in agreement with the above-stated action(s), you may appeal this decision by notifying, IN WRITING, within thirty (30) days of receipt of this letter:

APPEALS DIVISION
Department of Medical Assistance Services (DMAS)
600 E. Broad Street, Suite 1300
Richmond, VA 23219

This agency is required to inform you of your right to appeal, based upon State and Federal codes. (12 VAC [Virginia Administrative Code] 30-110-70 through 12 VAC 30-110-90) and Federal regulations (42 CFR [Code of Federal Regulations] 431).

If you have any questions regarding the actions noted in this letter, you may contact

_____ .

{ **Signature** }

TO: - MR VIRGINIA MEDICAID PRE-AUTHORIZATION NOTIFICATION FOR PROVIDER NUMBER 4945620 PRE-AUTHORIZATION REQUEST ACTIVITY FOR 9/21/95

-5505

PAGE 1

THE FOLLOWING REQUESTS FOR PRE-AUTHORIZATION WERE APPROVED AND MAY BE BILLED TO DMAS USING THE PROCEDURE CODES, DATES AND AMOUNTS AUTHORIZED.

ALL APPROVALS ARE CONTINGENT UPON THE RECIPIENT'S STATUS AS A MEDICAID ELIGIBLE RECIPIENT AT THE TIME THE SERVICE IS RENDERED. ALL APPROVALS ARE CONTINGENT UPON THE PROVIDER BEING ENROLLED WITH DMAS AT THE TIME THE SERVICE IS DELIVERED; NO PAYMENT WILL BE MADE FOR SERVICES DELIVERED BY A PROVIDER WHO IS NOT ENROLLED WITH DMAS ON THE DATE THAT THE SERVICE WAS DELIVERED. THE APPROVED COST PER UNIT IS THE AMOUNT CURRENTLY APPROVED BY THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AT THE TIME OF AUTHORIZATION. THESE REIMBURSEMENT AMOUNTS ARE SUBJECT TO CHANGE BASED ON FEDERAL AND STATE FEE ADJUSTMENTS. THE PAID MUST BE ENTERED ON EACH CLAIM OR THE CLAIM WILL BE DENIED. WHEN SUBMITTING CLAIMS FOR PRE-AUTHORIZATION SERVICES, PLEASE BE SURE THE MODIFIER (I.E., 01, 02, 03, ETC) LISTED NEXT TO THE PROCEDURE CODE IS ENTERED ON THE HCFA-1500 BILLING FORM IN LOCATOR 24D UNDER MODIFIER.

FAIRFAX-FALLS CHURCH CSB - MR
MR SERVICES
12055 GOVERNMENT CTR
PARKWAY STE 927
FAIRFAX VA 22035-5505

| RECIPIENT NUMBER/NAME | REFERENCE # | PA NUMBER | PROCEDURE (MODIFIER) | UNITS REQ/AUTH | DATES FR/THRU | APPROVED COST/UNIT | PRG/SER CATEGORY | APPROVAL REASON |
|--------------------------|-------------|-----------|-------------------------------------|-------------------|------------------|-----------------------|---------------------|--------------------|
| 0591 MILL | 0000000000 | 952640014 | Z8545 CASE MANAGEMENT, MENTAL RETAR | 0 | 10/01/95 | \$175.40 | MAIVER | 100 |
| 0591 HILL | 0000000000 | 952640014 | Z8551 CONGREGATE RESIDENTIAL SUPPOR | 1 | 99/99/99 | | | |
| 0591 HILL | 0000000000 | 952640014 | Z8551 CONGREGATE RESIDENTIAL SUPPOR | 0 | 10/01/95 | \$12.50 | MAIVER | 100 |
| 0591 HAY | 0000000000 | 941990216 | Z8551 CONGREGATE RESIDENTIAL SUPPOR | 259 | 99/99/99 | | | |
| 0591 JIL | 0000000000 | 941990216 | Z8551 CONGREGATE RESIDENTIAL SUPPOR | 0 | 10/01/95 | \$12.50 | MAIVER | 100 |
| | | | | 215 | 99/99/99 | | | |
| | | | | 0 | 6/01/95 | \$11925.00 | MAIVER | 100 |
| | | | | 1 | 7/01/95 | | | |

1001 REQUEST APPROVED

SAMPLE DMAS NOTICE

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES



NOTICE OF APPROVAL OF PRE-AUTHORIZED SERVICE

MARCH 26, 1997

TO:

MADISON HEIGHTS VA 24572-8849

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (MEDICAID) HAS APPROVED A REQUEST FOR:

PA # 942020259
DAY SUPPORT, CENTER BASED, REGULAR I PROVIDER: LYNCHBURG SHELTERED
UNITS 46 FROM DATE 04/01/96 THRU DATE 03/31/98

PA # 942020260
CONGREGATE RESIDENTIAL SUPPORT PROVIDER: CENTRAL VIRGINIA TR
UNITS 316 FROM DATE 04/01/97 THRU DATE 03/31/98

THIS APPROVAL IS ONLY GOOD AS LONG AS YOU ARE AN ACTIVE MEDICAID-ELIGIBLE RECIPIENT.

BOTH THE PROVIDER AND THE MEDICAL PROFESSIONAL WHO MADE THE REFERRAL FOR SERVICE HAVE BEEN NOTIFIED OF THIS APPROVAL. YOU DO NOT NEED TO TAKE ANY ACTION TO START THE DELIVERY OF THE APPROVED SERVICE(S). IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE PROVIDER OR THE MEDICAL PROFESSIONAL WHO MADE THE REFERRAL FOR SERVICE. IF, FOR ANY REASON, YOU NEED TO CHANGE PROVIDERS DURING THE PERIOD AUTHORIZED, THE AUTHORIZED PROVIDER MUST SUBMIT TO DMAS A REQUEST FOR CHANGE IN AUTHORIZATION TO ALLOW THE NEW PROVIDER TO BILL FOR THE SERVICE.

SAMPLE DMAS NOTICE

PATIENT INFORMATION

Medicaid ID: _____ **Provider Name:** _____
Recipient Name: _____ **SSN:** _____ **DOB:** _____
Address: _____

I. Provider Section

Payment Status (Complete Appropriate Blocks)

Report any admission, discharge, and/or change in patient status

Patient admitted to this facility/service on : _____ (date)

Level of care: ☐ Skilled ☐ Intermediate

Patient discharged or expired on _____ (date)

Discharged to: ☐ Home ☐ Hospital ☐ Other Facility ☐ Expired

☐ Case in Need of Review/DMAS-122 requested

☐ Personal Funds Account balance \$ _____

☐ Patient's income or deductions have changed

☐ Other/explain: _____

Prepared by

Name: _____ Title: _____

Telephone: _____ Date: _____

II. DSS Section

Eligibility Information: (Check One)

☐ Is eligible for full Medicaid services beginning _____ (date)

☐ Is ineligible for Medicaid services

☐ Is eligible for QMB Medicaid only

☐ Is ineligible for Medicaid payment of LTC services from _____ to _____ due to transfer of assets

☐ Is eligible for Medicare premium payment only

☐ Has Medicare Part A Insurance

☐ Has other health insurance

III. Patient Pay Information

| | MMYY | MMYY | MMYY |
|--------------------|-------|-------|-------|
| Patient Pay Amount | _____ | _____ | _____ |

Comments: _____

Note: Medicaid Long-term care providers cannot collect more than the Medicaid rate from the patient. Income is used for the cost of care in the month in which it is received, e.g. the SSA check received in January is used toward the cost of care in January.

Worker Name: _____

Agency Name: _____ FIPS Code: _____

Telephone: _____ Date: _____

PATIENT INFORMATION
FORM NUMBER DMAS-122

PURPOSE OF FORM—To allow the local DSS and the nursing facility or Medicaid Community-based Care provider to exchange information regarding:

1. The Medicaid eligibility status of a patient;
2. The amount of income an eligible patient must pay to the provider toward the cost of care;
3. A change in the patient's level of care;
4. Admission or discharge of a patient to an institution or Medicaid CBC services, or death of a patient;
5. Other information known to the provider that might cause a change in the eligibility status or patient pay amounts.

USE OF FORM—Initiated by either the local DSS or the provider of care. The local DSS must complete the form for each nursing facility or CBC waiver patient at the time initial eligibility is determined or when a Medicaid enrolled recipient enters a nursing facility or CBC waiver services. A new form must be prepared by the local DSS whenever there is any change in the patient's circumstances that results in a change in the amount of patient pay of the patient's eligibility status. The local DSS must send an updated form to the provider at least once a year, even if there is no change in patient pay.

The provider must use the form to show admission date, to request a Medicaid eligibility status, Medicaid recipient I.D., and patient pay amount; to notify the local DSS of changes in the patient's circumstances, discharge or death.

NUMBER OF COPIES—Original and one copy for nursing facility patients and original and two copies for CBC patients.

DISTRIBUTION OF COPIES—For nursing facility patients, send the original to the nursing facility and file the copy in the eligibility case folder. For Medicaid CBC patients, refer to section M1470.800 B.2. to determine where the original and any copies of forms are sent.

INSTRUCTIONS FOR PREPARATION OF THE FORM—Complete the heading with the name of the nursing facility or Medicaid CBC provider, the address, the patient's name, social security number, and Medicaid recipient I.D.

Section I is for the provider to complete. Section II must be completed by the local DSS. Fill in the appropriate spaces.

Eligibility information

1. Check the first block on an initial form sent in conjunction with the approval of a new Medicaid application, showing the effective date of coverage.
2. Check the second block if the individual is ineligible for payment of all Medicaid services.
3. Check the third block if the individual is eligible as QMB only-(not dually eligible).
4. Check the fourth block if ineligible for Medicaid payment due to transfer of assets. Dates of disqualification must be listed on the form. Send copy to DMAS.
5. Check the fifth block if eligible for Medicare premium payment only.
6. Check the sixth block if the individual has Medicare Part A insurance.
7. Check the last block if the individual has other health insurance.

Patient Pay Information

Enter the month and year in which patient pay amount is effective. Enter the patient pay amount under the appropriate month and year.

APPENDIX 1
Virginia EPSDT Periodicity Schedule

| | INFANCY | | | | | | | | | | EARLY CHILDHOOD | | | | LATE CHILDHOOD | | | | ADOLESCENCE | | | |
|--|---------|----|----|----|----|-------|---------|-----|-----|----------------|-----------------|---------|----|----|----------------|---------|-----|-----|-------------|-----|--|--|
| | By 1m | 2m | 4m | 6m | 9m | 12m | 15m | 18m | 24m | 3y | 4y | 5y | 6y | 8y | 10y | 12y | 14y | 16y | 18y | 20y | | |
| AGE ¹ | | | | | | | | | | | | | | | | | | | | | | |
| HISTORY | | | | | | | | | | | | | | | | | | | | | | |
| Initial/interval | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | | |
| MEASUREMENTS | | | | | | | | | | | | | | | | | | | | | | |
| Height and Weight | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | | |
| Head Circumference | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | | |
| Blood Pressure | | | | | | | | | | | | | | | | | | | | | | |
| SENSORY SCREENING | | | | | | | | | | | | | | | | | | | | | | |
| Vision ² | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | 0 ² | 0 | 0 | 0 | \$ | \$ | 0 | \$ | \$ | 0 | \$ | | |
| Hearing ² | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | 0 ² | 0 | 0 | 0 | \$ | \$ | 0 | \$ | \$ | 0 | \$ | | |
| DEVELOPMENTAL/BEHAVIORAL ASSESSMENT ³ | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | | |
| PHYSICAL EXAMINATION ⁴ | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | | |
| PROCEDURES GENERAL | | | | | | | | | | | | | | | | | | | | | | |
| Hereditary/Metabolic Screening ⁵ | ---- | | | | | | | | | | | | | | | | | | | | | |
| Immunization ⁶ | ---- | • | • | • | • | <---- | •-----> | > | • | | <---- | •-----> | > | | | •-----> | | | | | | |
| Lead Screening | | | | | | | | | | | | | | | | | | | | | | |
| Hematocrit or Hemoglobin ⁷ | <---- | | | | | | | | | | | | | | | <-----7 | | | | | | |
| Urinalysis ⁸ | | | | | | | | | | | | • | | | | <-----8 | | | | | | |
| PROCEDURES-PATIENTS AT RISK | | | | | | | | | | | | | | | | | | | | | | |
| Tuberculin Test ⁹ | | | | | | * | * | * | * | * | * | * | * | * | * | * | * | * | * | * | | |
| Cholesterol Screening ¹⁰ | | | | | | | | | | | | | | | | | | | | | | |
| STD Screening | | | | | | | | | | | | | | | | | | | | | | |
| Pelvic Exam ¹¹ | | | | | | | | | | | | | | | | | | | | | | |
| ANTICIPATORY GUIDANCE ¹² | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | | |
| Initial Dental Referral ¹³ | | | | | | <---- | | | | | | | | | | | | | | | | |

¹If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

²If the patient is uncooperative, rescreen within six months.

³By history and appropriate physical examination: if suspicious, by specific objective developmental testing.

⁴At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.

⁵Metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to State law.

⁶Schedule(s) per the Committee on Infectious Diseases, published periodically in Pediatrics. Every visit should be an opportunity to update and complete a child's immunizations.

⁷All menstruating adolescents should be screened.

⁸Conduct dipstick urinalysis for leukocytes for male and female adolescents.

Key: • = to be performed

* = to be performed for patients at risk

<-----> = the range during which a service may be provided, with the dot indicating the preferred age.

o = objective, by standard testing method

⁹TB testing per AAP statement "Screening for Tuberculosis in Infant and Children" (1994). Testing should be done upon recognition of high risk factors. If results are negative but high risk situation continues, testing should be repeated on an annual basis.

¹⁰Cholesterol screening for high risk patients per AAP "Statement on Cholesterol" (1992). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.

¹¹A pelvic examination and routine pap smear should be offered as part of preventive health maintenance between ages of 18 and 21 years.

¹²Appropriate discussion and counseling should be an integral part of each visit for care.

¹³Earlier initial dental evaluation may be appropriate for some children. Subsequent semi-annual examinations by a dentist

CRIMES RESULTING IN THE NEED FOR IMMEDIATE TERMINATION OF A CONSUMER DIRECTED ASSISTANT OR COMPANION

The CD Services Facilitator is responsible for notifying the fiscal agent whenever an assistant or companion is found to have been convicted of any of the following crimes per Section 32.1-162.9:1 of the Code of Virginia and 12 VAC 30-120-770. The assistant or companion will not be permitted to continue to provide MR Waiver Consumer Directed services.

- 1) murder, abduction for immoral purposes as set out in § 18.2-48;
- 2) assaults and bodily woundings as set out in Article 4 (§ 18.2-51 et seq.) of Chapter 4 of Title 18.2;
- 3) robbery as set out in § 18.2-58;
- 4) sexual assault as set out in Article 7 (§ 18.2-61 et seq.) of Chapter 4 of Title 18.2
- 5) arson as set out in Article 1 (§ 18.2-77 et seq.) of Chapter 5 of Title 18.2;
- 6) pandering as set out in § 18.2-355;
- 7) crimes against nature involving children as set out in § 18.2-361;
- 8) taking indecent liberties with children as set out in § 18.2-370 or § 18.2-370.1;
- 9) abuse and neglect of children as set out in § 18.2-371.1;
- 10) failure to secure medical attention for an injured child as set out in § 18.2-314;
- 11) obscenity offenses as set out in § 18.2-374.1 or § 18.2-379;
- 12) or abuse or neglect of an incapacitated adult as set out in § 18.2-369.

Section 32.1-162.9:1 of the Code of Virginia also specifies an applicant may be hired if the applicant is convicted of one misdemeanor specified in the convictions described in this section that do not involve abuse or neglect or moral turpitude, provided five years have elapsed since the conviction.

HOW CONSUMER-DIRECTED SERVICES WORK

(Approximately 30 days from Step 1 to Step 7)

STEP 1

You are newly enrolled in or already receiving MR Waiver services.

STEP 2

Upon your request, or at your initial or annual plan of care meeting, your case manager explains agency-directed and consumer-directed service options.

You choose consumer-directed services. Your case manager gives you the names and telephone numbers of possible services facilitators to help you hire and train your workers.

STEP 3

You interview and hire a facilitator.

STEP 4

Your facilitator helps you develop an Individual Service Plan (ISP), which describes the supports you are requesting. Within a week of developing your ISP, the facilitator discusses it with your case manager and completes the other paperwork required to get your services approved.

Within a week of receiving it, your case manager reviews your paperwork and sends it to the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.

STEP 5

Within a week of learning that your services have been approved, your facilitator trains you and your family on how to hire and supervise your workers, using a packet of employment information from the Virginia Department of Medical Assistance Services (DMAS).

STEP 6

You hire your worker(s). Your worker(s) and facilitator complete all employment paperwork, and send it to the DMAS fiscal agent, who ensures all employment and financial requirements are met.

STEP 7

Your facilitator notifies your case manager and fiscal agent that your CD services have started.

STEP 8

You sign time sheets of your worker(s) and send them to the fiscal agent (every 2 weeks), with the help of your facilitator as needed.

STEP 9

The fiscal agent pays your worker.

STEP 10

Your facilitator keeps in touch with you and checks on your satisfaction with services.

Employee Management Manual
for
the Mental Retardation Waiver's
Consumer-Directed Personal Assistant/Companion Services



Department of Medical Assistance Services

October 31, 2002

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PHILOSOPHY

THERE ARE MANY VIRGINIA CITIZENS, WHO, ALTHOUGH HAVING MENTAL RETARDATION, ARE QUITE CAPABLE OF MANAGING THEIR OWN LIVES.

Many citizens with mental retardation, or their family/caregiver, are able to directly control their own service needs. If these individuals, or family/caregiver, hire and manage their own assistants and companions, rather than depend solely on family members or providers, many will be able to achieve greater independence.

Under the traditional system of community-based services, individuals with mental retardation are dependent upon the schedules of providers, and services are usually available only during limited hours (seldom at night or on the weekends). Individuals with mental retardation have needs throughout the entire week, and greatly benefit from a system allowing the flexibility to obtain the services when needed. Just as a prescription for medication is useful only when a person is ill, services are helpful only when needed. While providers provide a very important service, they often cannot help individuals with mental retardation attain the independence they desire to achieve.

Having an Assistant/Companion allows for flexibility and control by you, the individual or the family/caregiver. This philosophy developed from the fact that individuals with mental retardation are not ill; they simply cannot do for themselves what other people can do. Therefore, directing the assistant/companion in these activities may be all that is needed to achieve or maintain an independent lifestyle.

It has been determined that you are eligible to participate in the Mental Retardation (MR) Waiver's Consumer-Directed Services. After you have signed the contracts accepting consumer directed services, a contract with the Consumer Directed Services Facilitator and a contract with the Fiscal Agent (Appendixes A, B, C) and successfully completed this training, you will be able to employ your own assistant/companion.

DEFINITION OF SERVICES UNDER MEDICAID-FUNDED CONSUMER-DIRECTED SERVICES

Consumer-Directed (CD) Assistant/Companion Services are defined as long-term maintenance or support services which are necessary to enable an individual to remain at or return home rather than enter a nursing facility, an assisted living facility, an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or a hospital. **Assistant/companion services provide eligible individuals with a personal assistant/companion who perform basic hands on health-related services, such as helping with walking/wheeling and exercises, assisting with normally self-administered medications, and/or providing household services essential to health in the home.** Specifically, assistant/companion services include assistance with personal hygiene, nutritional support, and the environmental maintenance necessary for individuals to remain in their homes or community.

Medicaid-funded assistant/companion services under the MR Waiver cannot be offered to individuals who are residents of nursing facilities, assisted living facilities, ICF/MR, or adult foster/family homes approved by the Virginia Department of Social Services.

Consumer-Directed (CD) Respite Services means services offered in the MR Waiver that are specifically designed to provide temporary but periodic or routine relief to the primary unpaid caregiver living with the individual who has mental retardation. CD Respite Services includes assistance with basic health-related services. Caregivers can receive up to 720 hours of CD Respite services per calendar year. Caregivers can receive both agency-directed and consumer-directed respite services, but the total number of hours for both services cannot exceed 720 hours per calendar year.

Consumer-Directed (CD) Services Facilitator means an individual or agency enrolled by the Department of Medical Assistance Services (DMAS) to provide supportive services to the individual or family/caregiver. The CD services facilitator may be a registered nurse with a current Virginia nursing license or a human services college graduate who is responsible for ensuring the assessment, development and monitoring of the individual's service plan, providing management training, and reviewing service needs with the individual and/or family/caregiver.

Consumer Service Plan means the document created by your case manager that addresses your needs in all life areas. It includes all the individual service plans developed by MR Waiver service providers and your CD Services Facilitator.

Department of Medical Assistance Services ("DMAS") is the state agency that is responsible for managing the MR Waiver.

Fiscal Agent means an agency or organization that may be contracted by the Department of Medical Assistance Services to handle employment, payroll, and tax responsibilities on behalf of the individual or family/caregiver who is utilizing consumer-directed services in the MR Waiver. DMAS is the fiscal agent for the MR Waiver.

Individual Service Plan (ISP) means the plan of care identifying the specific services to be provided by the personal assistant/companion..

COVERED SERVICES

The covered services that your personal assistant/companion provides are limited to those services that are defined as personal assistant/companion services. These services are **limited** to the following:

- Assisting with care of the teeth and mouth;
- Assisting with grooming (this would include care of the hair, shaving, and the ordinary care of the nails);
- Assisting with your bathing in bed, in the tub, the shower, or a sponge bath. Routine maintenance and care of external condom catheters is considered part of the bathing process. This care applies only to external and not in-dwelling catheters, i.e., Foley catheters;
- Providing routine skin care, such as applying lotion to dry skin; not to include topical medications and/or any type of product with an “active ingredient”;
- Assisting you with dressing and undressing;
- Assisting you to turn and change position, transfer (move around), and ambulate (walk or wheel);
- Assisting you to move on and off of the bedpan, commode, or toilet;
- Assisting you with eating or feeding;
- Assisting you with normally self-administered medications and assuring that you receive medications at prescribed times. This does not include pouring or, in any way, determining the dosage of the medication. This DOES NOT include INJECTABLE MEDICATIONS;
- Assisting you with work-related supports;

Transportation

The personal assistant/companion may be allowed to transport you in your primary vehicle or accompany you to assist you with your activities of daily living (“ADLs”) or instrumental activities of daily living

("IADLs") as stated and documented in your plan of care. The personal assistant/companion may drive you **ONLY IN YOUR PRIMARY VEHICLE** if all of the following criteria are met:

- The total time required by the personal assistant/companion for the day, including the time required to drive you does not cause your weekly authorized hours to be exceeded. If the total time required exceeds the daily hours, the additional time may be deducted from another day as long as this does not jeopardize your health and safety;
- Your vehicle is currently registered in the State of Virginia;
- You have **current** automotive insurance that will insure the personal assistant/companion as a driver of your vehicle;
- The personal assistant/companion has a current, valid Virginia driver's license; and
- The driving of your vehicle by the personal assistant is necessary to assist you with achieving the goals on your plan of care.

The following services will require oversight by your CD Service Facilitator before the personal assistant/companion can perform them:

- Administration of bowel and bladder programs as stated in the plan of care by the personal assistant/companion under special training and supervision. The personal assistant/companion may be authorized to administer physician-ordered bowel and bladder programs to individuals who do not have any other support available. This authorization could only be given if the Service Facilitator has documented that the personal assistant/companion has received special training in bowel and bladder program management, has knowledge of the circumstances that require immediate reporting to the individual's physician, and a Registered Nurse (RN) contracted by the Service Facilitator has observed the personal assistant/companion performing this function.

Certain conditions exist that would contraindicate having your personal assistant/companion perform a bowel program. For instance, some quadriplegics, head and spinal cord injured individuals, and some stroke individuals may be prone to dysreflexia. The bowel program may include, if necessary, a laxative, enemas or suppositories to stimulate defecation. However, a laxative cannot be “administered” by the personal assistant/companion, even through part of the bowel program (suppositories are an exception to this and can be administered if ordered by the physician as part of a bowel program). Replacement of a colostomy bag as part of the bath is included. Digital stimulation and removal of feces within the rectal vault may be a necessary part of the bowel maintenance or training program. However, removal of impacted material by your personal assistant/companion is not allowed. (None of the procedures included here may be administered except as part of a physician-ordered bowel program).

The bladder program performed by your personal assistant/companion may not include any invasive procedures such as catheterization, instillation or irrigation, but can include bladder training activities. Bladder retraining by your personal assistant/companion is limited to time management of urination without any invasive procedures or voiding stimulation. The RN contracted by your Service Facilitator will be available to you and will be able to respond to any complications that may arise immediately or you may request that skilled nursing services be added to your Consumer Service Plan;

- Administration of range of motion exercises by the personal assistant/companion as stated in the plan of care. Range of motion exercises ordered by the physician may be performed by your personal assistant/companion when the personal assistant/companion has been instructed by an RN (contracted by the Service Facilitator or included in your CSP) in the administration of maintenance of range of motion exercises, and the assistant/companion’s correct performance of these exercises has been witnessed and documented by an RN. This does not include strengthening exercises or exercises aimed at retraining muscle groups, but includes only those exercises used to maintain current range of movement without encountering resistance;
- Your personal assistant/companion may provide routine wound care, which does not require sterile technique if it is stated in the plan of care. The personal assistant/companion can perform routine wound care that does not include sterile treatment or sterile dressings. This would include the care of a routine decubitus (or pressure sore). The pressure sore must be superficial and not exceed stage 2. A stage 2 pressure sore penetrates to the underlying subcutaneous fat layer, shows redness, edema, and induration, and at times shows epidermal blistering or peeling). Normal wound care would include flushing with normal

saline solution, washing the area, drying the area, and applying dry dressings as instructed by the RN. This does not include the application of any creams, ointments, sprays, powders, or occlusive dressings;

- Home Maintenance Activities ~ These activities are related to the maintenance of the home or preparation of meals should only be included on your ISP if you do not have someone available to assist you with this. When someone is living with you, this person is expected to perform housekeeping and cooking activities for themselves and provide your home maintenance activities while completing their own. These activities are:

- Preparing and serving meals, not to include menu planning for special diets;
- Washing dishes and cleaning the kitchen;
- Making the bed and changing linens;
- Cleaning your bedroom, bathroom, and rooms which are primarily used by you;
- Listing for purchase the supplies needed;
- Shopping for necessary supplies if no one else is available to perform the service; and
- Washing your laundry if no other family member is available or able.

SERVICES EXCLUDED FROM COVERAGE

The Department of Medical Assistance Services (“DMAS”) **will not reimburse** personal assistant/companion for any services that are not listed on the previous page. Below are descriptions of specific exclusions.

Skilled Services

Any services requiring professional skills or invasive therapies such as tube feedings, Foley catheter irrigation, sterile dressing, or any other procedures requiring sterile technique, **CANNOT BE PERFORMED BY THE PERSONAL ASSISTANT/COMPANION**. Routine maintenance and care of external condom catheters does not constitute a skilled service and can be performed by the personal assistant/companion as part of the bathing process.

Skilled services cannot be listed on your ISP as a service that is to be provided under this program. If you have questions about what is or is not a skilled service, talk to your CD Service Facilitator.

Providing Services for Other Members of Your Household Who Are Not Medicaid Consumer-Directed Services Recipients

DMAS will reimburse the personal assistant/companion only for services rendered to you. DMAS will not reimburse the personal assistant/companion for services rendered to or for the convenience of other members of your household (e.g., cleaning rooms used equally by all family members, cooking meals for the family, washing dishes, family laundering, etc.). DMAS also will not reimburse for the provision of unauthorized services.

**IF THE PERSONAL ASSISTANT/COMPANION PERFORMS ANY OF THESE SERVICES
DURING THE TIME THAT MEDICAID IS PAYING FOR THE SERVICE,
YOU MAY BE REMOVED FROM THE PROGRAM.**

REQUIREMENTS FOR PERSONAL ASSISTANTS/COMPANIONS

For each personal assistant/companion you hire, you must evaluate the personal assistant/companion to ensure compliance with the minimum qualifications as required by the Department of Medical Assistance Services. The minimum qualifications for personal assistants/companions include the following:

- Be 18 years of age or older;
- Possess basic math, reading, and writing skills;
- Have the required skills to perform services as specified in your supporting documentation;
- Possess a valid Social Security number;
- Submit to a criminal history record check. The personal assistant/companion will not be compensated for services provided to you if the records check verifies the personal assistant/companion has been convicted of crimes that are described in the Code of Virginia §37.1-183.3 or if the personal assistant/companion has a complaint confirmed by the DSS child protective services registry. Personal assistants/companions will be reimbursed for services provided prior to the results of a criminal history record check or a child protective services registry confirmation.
- Be willing to attend/receive training at the individual's or family/caregiver's request;
- Receive annual cardiopulmonary resuscitation training, an annual flu immunization(unless medically contra-indicated), and periodic tuberculosis testing; and
- Understand and agree to comply with the consumer-directed service requirements.

Personal assistants/companions may **NOT** be members of the individual's/caregiver's family living under the same roof as the individual receiving services. In addition, parents of minor children, the individual's spouse, or legally responsible relatives of the individual may not be personal assistants/companions for the individual receiving services.

If the personal assistant/companion is a family member, there must be objective written documentation as to why there are no other providers available to provide the service.

You should verify information on the application form prior to hiring a personal assistant/companion. It is important that the minimum qualifications be met by each personal assistant/companion hired to ensure your health and safety.

EMERGENCY BACK-UP PERSONAL ASSISTANT/COMPANION CARE

What do you do when you suddenly find yourself without a personal assistant/companion as scheduled? This can be a very anxiety-producing situation; however, preventive action can be taken so you are not left without services.

It is unlikely that a personal assistant/companion is going to be able to work 365 days per year. Therefore, it is essential that you have available a list of people to call in an emergency.

To prepare you for when you find yourself without a personal assistant/companion, certain steps can be taken:

1. Take the time now to review your essential service needs. It is important to be reasonably flexible in time of crisis. Remember, you may have to modify your schedule, get along with less support than usual, and/or skip non-essential activities in order to get basic needs met. Preparing a brief description of your essential needs will help you be more specific when you approach people to serve as a backup.
2. Develop a list of people who can be available as emergency backup personal assistants/companions for you. This list would include family and friends, former personal assistants/companions, people you go to school with, volunteer with, or know from church or social organizations, and finally, other working personal assistants/companions you know. The CD services facilitator shall ensure you have an emergency backup plan in place during the development of the ISP.
3. Develop a short descriptive letter to recruit other emergency backup assistants/companions. It can be sent to many places where people may be looking for extra work. Refer to the list of resources in the advertisement section of this manual.
4. If the people you recruit to be emergency back-ups are people you don't know, interview them as you would any personal assistant/companion, give them a job description and information about jobs and salary. Add their names, phone numbers and hours they are able to work to the backup list you have made.
5. It is important that the total time worked by all personal assistants/companions does not exceed the hours you are authorized to receive in your CSP. Personal assistants/companions will not be reimbursed for hours worked that exceed the number of authorized hours.
6. Every six months or so, update your emergency backup list. A brief phone call to check if the people are still interested and if they have any changes in the times they are available is recommended.

The following list of ideas may help you in the event that a back up is needed:

1. Begin the process as quickly as possible. Even a few hours lead time may give your back-up person an edge in being able to rearrange their schedule to meet your request.

2. Take a few minutes to collect your thoughts before you begin calling people on your list. Make sure you know the answers to the following questions:
 - What kind(s) of assistance am I requesting?
 - What times and for how long do I need them?

Keep in mind that the best way to deal with a crisis is to prevent it. An adequate back-up system is essential to a safe and effective personal assistant/companion network. Furthermore, it is a requirement of consumer-directed services.

MY NEEDS INVENTORY

Communicating your needs clearly is an important skill to have when working with a personal assistant/companion. Before you can do this it is important to have your needs well defined and in as much detail as possible. The following worksheet will help you to be very specific about the different aspects of personal assistance/companion services that you need:

Personal Assistance Needs

- Bathing: Type of bath (shower, bed bath, set-up)? How often? What time of the day? How long does it take?
- Dressing: Complete assistance? Partial assistance? Special considerations? How long does this take?
- Oral Care: How often?
- Toileting: Bedpan? Commode, toilet?
- Transferring: Type of transfer? When needed? Special considerations?
- Eating: Other than meal preparation, any special help? Special diet?
- Medication: Type? How often needed? Who administers?
- Exercises: Type? How often? How long does it take?

Homemaking Needs

- Laundry: How often? Where done?
- Housecleaning: How often? How many rooms? Specific chores?
- Meal Preparation: Times of meals? Who will plan?
- Grocery Shopping: How often? Where? Who will go?

Other Needs

Finances: Help with banking, checking, or correspondence?

Transportation needs: Special equipment needs? Equipment maintenance?

Work-related supports:

Companion Needs:

Because you will be working closely with a personal assistant/companion, it is important that you have a clear understanding of your needs, and an awareness of your own personal habits and skills. Completing this worksheet may also help you discover areas where you may need to gain more knowledge. For example, if you have never had to be responsible for housekeeping, you may need to learn what kinds of household products are needed and how they are used because it's possible that your personal assistant/companion may need direction from you in this area. Also, this worksheet can help you decide what information about your personal habits you feel is important to communicate to your personal assistant/companion.

ASSESSING MY NEEDS

FOOD AND EATING ARRANGEMENTS

1. What kind of foods do I usually eat? Like? Dislike?
2. Am I good at supervising someone who cooks?
3. Where do I shop for groceries?
4. Do I eat at regular times or when I feel like it?
5. How do I feel about eating with my personal assistant/companion?
6. How do I feel about giving cooking instructions to my personal assistant/companion?
7. If I like different foods than my personal assistant/companion, will I be willing to eat what he or she likes?

HOUSEKEEPING

1. What do I know about housekeeping and laundry?
2. Do I like things very neat or am I not particular?
3. How do I feel about giving cleaning instructions?
4. Would I like a definite schedule for cleaning and laundry, e.g., vacuum on Monday, scrub on Tuesday, or would I prefer to be more flexible?

HYGIENE

1. How often do I need to bathe?
2. How often do I need a shampoo?
3. Is my personal appearance important to me?

PERSONAL HABITS

1. Do I smoke?
2. Do I drink alcohol?
3. Do I like to sleep late in the morning or get up early?
4. What time do I usually go to bed at night?
5. Do I go out to visit friends and to participate in other social activities?
6. Will I want to entertain friends and family in my apartment/home?
7. Would it be troublesome to me if my assistant/companion wanted to have a friend come with them?
8. Do I usually like activities well planned or do I like them to be spontaneous?
9. What do I like to do for entertainment?
10. Do I like to listen to music? What kind? What volume?
11. Do I like a quiet atmosphere?
12. Do I like to watch TV?
13. What hobbies do I have?
14. Do I consider myself a flexible person? Example?
15. How do I react if I have to change my plans at the last minute?
16. Describe my personality!
17. Is there a spiritual aspect to my life that is important?
18. In general, could it be said that I take responsibility for my own life?

PERSONAL ASSISTANT/COMPANION JOB DESCRIPTIONS

Now that you have clearly defined your needs and examined your lifestyle, you are ready to make a formal job description for yourself. The following are some reasons why it is important to do this:

1. In the process of developing a job description, you, the employer, discover a realistic picture of your own limitations and your lifestyle.
2. It can be used as a guideline for more in-depth questions in the interview process.
3. It will give a prospective employee some idea of what the position requires.
4. After a person has been hired, the job description can serve as a checklist of duties and responsibilities of the position.
5. You, the employer, can use it as an evaluation tool of the personal assistant's/companion's performance on the job.
6. The job description guides you so you do not take advantage of your personal assistant/companion.
7. It can be used if there are disagreements between the two of you as to what his or her duties are.
8. This job description can help to keep the communication lines open.

The key to a well-organized, effective assistant/companion network is a clear, concise job description. You should prepare a JOB DESCRIPTION based on your ISP as it relates to your needs.

A job description is used to define the job, manage time, and schedule personal assistants/companions. You should have your job description ready to hand out with each interview.

A sample job description is attached and may serve as a guide when you draft your own job description. Remember, job descriptions are individualized. Furthermore, a detailed description as to how to complete listed tasks should be provided to the personal assistant/companion during the training process.

The purpose of a job description is to provide the prospective employee with a brief description of his or her day-to-day responsibilities as your personal assistant/companion. It is not intended to replace any aspect of training or direction by you. Furthermore, you should make it a point to clarify that one single personal assistant/companion is not responsible for all activities listed, rather, that he or she may be expected to assist with any of the listed components depending on his or her work schedule.

As of July 1, 2000, the pay rate for personal assistants/companions is \$7.75 per hour for the Rest of State, and \$10.00 for Northern Virginia.

SAMPLE JOB DESCRIPTION

I use a PERSONAL ASSISTANT/COMPANION to assist me with my service needs:

WEEKDAY: _____

WEEKEND: _____

EVENINGS: _____

My personal assistants/companions are required to assist me with activities of daily living that include:

Bathing: _____

Transfers: _____

Grooming: _____

Hygiene: _____

Exercise: _____

Meal

Preparation: _____

Housekeeping: _____

Dressing: _____

Helping to

Bathroom: _____

Laundry: _____

Grocery
Shopping: _____

Correspondence,
Finances: _____

Transportation: _____

NOTE: I expect my personal assistant/companion to be punctual, neat, honest, and enjoy working with people. You must have a current, valid Virginia driver's license and I ask that you dress casually. Please give me two hours notice if you are going to be late or sick and one weeks notice for planned days off.

When performing hygiene services to my body (or my child's body), please inform me of any bruises, scrapes, or skin problems.

I would appreciate at least two weeks or a month's notice if you have to leave this job.

Please feel free to ask any questions in regards to my service needs. I feel more comfortable when people understand the purpose behind my service activities.

The reimbursement rate for Consumer-Directed Services is set by the Virginia Department of Medical Assistance Services. It is not a negotiable rate.

PERSONAL ASSISTANT/COMPANION ADVERTISING

Now that you have assessed your needs, developed an ISP with your CD services facilitator, and created a job description, you are ready to advertise for a personal assistant/companion. Be as creative and imaginative as you can in selecting where and how to advertise.

Your CD service facilitator may have names of people interested in working as personal assistants/companions, but there may not be anyone available who meets your particular needs ~ you may need to recruit elsewhere.

There are many ways to look for personal assistants/companions. Please find below, suggestions for advertising.

GENERAL SUGGESTIONS

How to advertise is as important as where to advertise. The three essential components of your ad will be a description of the position being offered, a list of qualifications needed and a means by which the applicants can reach you. In describing the job, you must describe yourself to some extent. In doing so, do not be too specific about your disability, because people may have fears based on misconceptions about it. “Disabled individual,” “using a wheelchair for mobility,” or such phrases broadly indicate the nature of your disability, especially if advertising in the local newspaper.

Except when appealing to trained personnel, do not be too specific in your ad about the responsibility of the job. Use non-specific phrases such as “assistance with personal care” or just “care.” It is best not to commit yourself in print to a specific pay rate.

When listing qualifications for the position, remember that the more restrictive you are, the fewer applicants you get.

Print your telephone number or Post Office box number in the ad so that applicants can reach you. It is unwise to indicate your name or address. Doing so will expose you to the possibility of being harassed by undesirable applicants or victimized by persons who think a disabled person living alone may be vulnerable.

Allow ample time for advertising for a personal assistant/companion prior to your anticipated need.

NEWSPAPER ADVERTISING

One of the fastest ways to reach the greatest number of people is through newspaper advertising. There are, however, two negative points about advertising through the newspaper; (1) placing an ad costs money depending on the length of the advertisement and how long you run it in the paper; and (2) newspaper ads involve contact with the general public that may have the potential to become a problem of unwanted phone calls.

SCHOOLS AND COLLEGES

Another resource for locating personal assistants/companions is schools and colleges. One of the many ways to bring your job offer to the attention of students is to have it listed at the student employment office of

schools and colleges. Obtaining the listing can be handled over the telephone or by mailing the information to the office. To write the job notice, be sure to observe the general guidelines listed above, except that these offices will ask you to include your name and usually your address, too. Other good places to have a job notice are at college off-campus housing offices and the Financial Aid office. A third idea is to have notices posted on bulletin boards at schools that have programs in health care or rehabilitation. Check your local yellow pages for local colleges or schools as possibilities.

OTHER OPTIONS

Local Newsletters (e.g., community groups, special interest groups, church groups, etc.)

Job Service or Employment Office

Bulletin Boards in Apartments, Grocery Stores

Word of Mouth (Friends who use assistants/companions)

Social Service Agencies

Health Care Agencies, Community-Based Service Programs

Hospitals, Nursing Homes

* It is not advisable to use radio or television announcements to advertise for personal assistants/companions.

The costs associated with hiring a personal assistant/companion are your own expense. The Department of Medical Assistance Services does not reimburse you for advertising or hiring expenses.

**SAMPLE ADVERTISEMENTS FOR
HIRING A PERSONAL ASSISTANT/COMPANION**

“Part-time personal assistant/companion needed for disabled female. Assist with personal hygiene, grocery shopping, and housekeeping. For more information, call or write....”

“Part-time personal assistant/companion needed for disabled male, 8:00 a.m. to 12 noon weekdays. Help with personal hygiene, grocery shopping, and housekeeping. Call...”

“Young physically disabled adult needs part-time personal assistant/companion to maintain independent lifestyle. Hourly wage. Call _____ after 9:30 a.m.”

“Part-time personal assistant/companion to provide respite services for teenage male. Assist with personal hygiene and provide supervision. Call...”

SAMPLE PERSONAL ASSISTANT/COMPANION APPLICATION

Name: _____ **Phone:** _____

Address: _____ **ZIP Code:** _____
 Street City State

How long have you lived there? _____

Sex: _____

In case of emergency, notify: _____

Experience in personal assistance/companion services?
 _____ How long? _____ If so, where? _____

Date Available: _____

Hours willing to work: _____ **Part-time** _____ **Days** _____ **Nights**
 _____ **Weekends** _____ **Back-Up**

How many hours per week? _____

Permanent _____ **Temporary** _____

Are you willing and able to do emergency back up work? _____

What is your means of transportation? _____

Do you have a valid Virginia Driver's License? _____

Have you been convicted of a felony or misdemeanor or other offense within the past five years?

If so, please explain _____

Are there any jobs that you would not want to do (for example, work for opposite sex, duties listed in job description, etc.)? _____

Who referred you? _____ **Salary Acceptable** _____

Restrictions on location of employment: _____

The answers given in this application are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision. I understand that this application is not a contract of employment.

Applicant Signature _____ **Date** _____

QUALIFICATIONS FOR EMPLOYMENT AS A PERSONAL ASSISTANT/COMPANION

Name of Applicant _____

| Street Address | City/Town | State | Zip Code |
|----------------|-----------|-------|----------|
|----------------|-----------|-------|----------|

County

Because of the need to protect the health and welfare of the individual with mental retardation, the Consumer-Directed Services of the MR Waiver has established the following standards for the employment of personal assistants/companions:

Minimum Qualifications for Employment as a Personal Assistant/Companion for Consumer-Directed Services of the MR Waiver

1. Be 18 years of age or older;
2. Have the required skills to perform assistant/companion services as specified in the individual's ISP;
3. Possess basic math, reading, and writing skills;
4. Possess a valid Social Security number;
5. Receive annual CPR training, periodic TB testing and an annual flu immunization (unless medically contra-indicated);
6. Be willing to submit to a criminal records check, and if the individual is a minor, a check of the DSS child protective services registry; and
7. Demonstrate the capability to perform activities required by the individual and/or specified in the individual's ISP, or be willing to receive training in performance of the specified activity

The applicant's signature on the line below acknowledges that he or she has been provided this information and has read the qualifications for employment as a Personal Assistant/Companion in the Consumer Directed Services of the MR Waiver.

I acknowledge that I have received and read the “Minimum Qualifications for Employment as a Personal Assistant/Companion in Consumer-Directed Services of the MR Waiver.”

Applicant Signature _____ Date _____

SCREENING APPLICANTS AND SCHEDULING INTERVIEWS

After placing the job ad, be prepared to receive phone calls, especially if you placed your ad in the local newspaper. It will be to your advantage to carefully screen calls from prospective assistant/companions who are calling in response to your advertising. It is important when talking on the phone to be friendly and pleasant. You will need to find out what kind of hours and rates of pay interest the applicants. If they want more pay than what is allowed or if they cannot work the hours you need, you do not have to interview them.

If the required hours and transportation availability are not a problem, you may want to give a brief description of the job and pay rate. Keep the job description near the phone, along with paper and pencil, in case you need to write information down, enlist the assistance of a friend or family member, or use a tape recorder, (if you cannot write). By discussing the important aspects of the job now and also discussing the minimum qualifications required of the applicant, you may be able to determine that a person would not be appropriate for this job and save time for both of you. If the applicant is still interested in the job, you should now set up a time to conduct a formal, personal interview.

It is recommended that you have the applicant come to your home or other designated area to fill out an application and complete an interview. At that time, you can further assess the person. Is he or she dressed neatly; polite; willing to discuss job responsibilities? The purpose of the interview is to learn as much as you can about the applicant and their qualifications and to give him or her as much information about the required job duties so that both of you have enough information to make a good decision.

We have enclosed a sample personal assistant/companion application for your use. You will need to modify it depending on your specific needs.

INTERVIEWING A PROSPECTIVE PERSONAL ASSISTANT/COMPANION

Through your initial screening you have arranged to interview only those applicants who are good candidates for the job. Your primary goal in the interview process is to learn about the potential personal assistant/companion and to assess if he or she is someone with whom you would be comfortable working. It is not easy to gather a lot of information in a short period of time; however, there are ways to conduct the interview so that enough information is made available to make a reasonably good choice.

When scheduling interviews, allow enough time between appointments to gather your thoughts and take down notes about the person being interviewed. If you interview several people it can be hard to recall things you liked or disliked. It is also helpful to list and rank in order, the characteristics you feel are important in a personal assistant/companion. After each interview, you can determine which of these characteristics the applicant demonstrated.

SUGGESTED INTERVIEWING STEPS

1. When the applicant arrives, welcome him or her, introduce yourself, and ask him or her to make himself or herself comfortable.
2. Explain your disability, if you feel comfortable doing so.
3. Have your written job description ready to give to the applicant and be prepared to discuss it in detail. Include the rate of pay, pay days, and lag time in payment. You may also provide a copy of your schedule (personal assistant/companion times) to show him or her the hours available for hire. Ask for any questions that the applicant may have.
4. Ask the prospective applicant about jobs he or she has had in the past. For example:
 - a. What jobs have you held in the past?
 - b. How do you feel about those jobs? What did you like or not like?
5. Ask for at least two (2) references from past employers.
6. Ask the prospective applicant why he or she wants this kind of work.
7. Talk about how you will evaluate his or her performance. Let him or her know that you want feedback about how things are going for him or her.

There are some qualities that you can assess in these first few minutes. Is the applicant on time? Is he or she clean and neat? Does he or she maintain good eye contact while you are describing the position and ask questions and appear interested in what you have to say? It is very important to check work references of the applicants as sometimes this is the only way to find out if he or she has had problems on the job in the past. You can call his or her previous employers and explain the job the person is applying for and ask questions regarding that person's dependability, honesty and ability to relate well with others. There may be other questions you wish to ask. However, you will also need to be flexible because not everyone will have work references or sometimes a person will have a negative reference he or she feels is unfair. Under these circumstances you may want to consult someone else before making a decision.

QUESTIONS TO THINK ABOUT WHEN YOU INTERVIEW A PERSONAL ASSISTANT/COMPANION

During the interview, keep in mind the qualities that you like in other people. This person does not have to become your best friend, but should be someone you can like and respect. The following questions may help you discover if your lifestyles are compatible, but do not limit yourself to them:

FOOD AND EATING ARRANGEMENTS

1. What kinds of foods do you usually eat? What do you like or dislike?
2. Are you a good cook?
3. Where do you shop for groceries?
4. Do you eat at regular times or when you feel like it?
5. How do you feel about eating together?
6. If you like different foods than I do, will you be willing to prepare my meals and yours?

TRANSPORTATION

1. How do you feel about accompanying me on errands?

HOUSEKEEPING

1. Have you had experience with housekeeping and laundry?
2. Do you like things very, very neat or are you not particular?
3. How do you feel about taking cleaning instructions from me?
4. Do you like a definite schedule for cleaning and laundry, e.g., vacuum on Monday, scrub floors on Tuesday, etc., or do you prefer to be more flexible?

PERSONAL HYGIENE

1. Would it bother you to help me with toileting or dressing, if necessary?
2. Will you be able to bathe me?
3. Is there any aspect of personal hygiene that you feel uncomfortable with?

PERSONAL HABITS, ETC.

1. Do you smoke?
2. Do you sleep late in the morning or get up early?
3. What time do you usually go to bed at night?
4. Do you go out to see your friends?
5. Will you expect to entertain your friends in my home/apartment? All the time? Some of the time? Never?
6. Do you usually like activities well planned, or do you like to do things on the spur of the moment?
7. What do you like to do for entertainment?
8. Do you like to listen to music? What kind? At what volume?
9. Do you like quiet surroundings?
10. Do you like to watch TV?
11. What hobbies do you have?
12. Do you consider yourself a flexible person? What examples can you give?
13. How do you react if you have to change your plans at the last minute?
14. Describe your personality!
15. What do you personally expect to give to this job?
16. Do you have any emotional or health problems that might interfere with your work?
17. Do you have any questions about the job description or what I have explained to you regarding the position?

While you are conducting the interview, listen carefully to what the other person is saying to you. Does he or she answer questions completely? Can he or she meet your schedule requirements? Does this person appear to be reliable and responsible?

If you are still unsure about the qualifications of the person whom you have interviewed, you may want to conduct a second interview. Ask key questions to further determine his or her suitability to work for you. It is during the second interview that the contract procedures can be explained.

NEVER MAKE A HASTY CHOICE. Do not, under any circumstances, hire an assistant/companion over the telephone. Always interview more than one person. Do not disregard qualified applicants. Keep their applications on file and inquire if they would be available to be a backup assistant/companion.

You may want to have another person available with you as you interview a prospective personal assistant/companion.

PERSONAL ASSISTANT/COMPANION WORK RECORD

PLEASE LIST MOST RECENT EMPLOYER FIRST:

Employer: _____
Address: _____ ZIP Code: _____
Work you performed: _____
Dates of Work: From: _____ To: _____
Reason for Leaving: _____

Employer: _____
Address: _____ ZIP Code: _____
Work you performed: _____
Dates of Work: From: _____ To: _____
Reason for Leaving: _____

Employer: _____
Address: _____ ZIP Code: _____
Work you performed: _____
Dates of Work: From: _____ To: _____
Reason for Leaving: _____

Employer: _____
Address: _____ ZIP Code: _____
Work you performed: _____
Dates of Work: From: _____ To: _____
Reason for Leaving: _____

Please list two (2) work-related references, including the name, address, phone number, and the relationship of the reference:

1. _____
_____ Zip _____
Phone _____ Relationship _____
2. _____
_____ Zip _____
Phone _____ Relationship _____

I understand that the information provided will be used in pursuit of employment.

Signed: _____ Date: _____

REFERENCE CHECK

FOR: _____

DATE: _____

RELATIONSHIP TO ABOVE: _____

DATES EMPLOYED: _____

ATTENDANCE RECORD: _____

WOULD RATE WORK: **HIGH** **AVERAGE** **BELOW AVERAGE**

STRONG POINTS: _____

WEAK POINTS: _____

| | | | |
|-------------------------|------------|-------------------------------|-----------|
| WOULD RECOMMEND: | YES | YES, WITH RESERVATIONS | NO |
| WOULD RE-HIRE? | YES | YES, WITH RESERVATIONS | NO |

CHECK DONE BY:

SPOKE TO:

DATE:

HIRING

When you hire a personal assistant/companion, you should review:

1. The personal assistant/companion job description.
2. The written job contract; at this time, you and your assistant/companion must sign the contract.
3. Review the days and time schedule that you expect your personal assistant/companion to work; confirm the starting date. Be sure to arrange for days and weekends off for your personal assistant/companion. This is important to maintain a good working relationship. A substitute personal assistant/companion could work on your personal assistant/companion's day off.
4. Arrange a time for a job training session, if needed.
5. The personal assistant/companion must complete and sign an I-9 form and provide documentation showing US Citizenship for an alien allowed to work (e.g., birth certificate, Social Security card, or driver's license).
6. You and the personal assistant/companion must review, in detail, and sign the Personal Assistant/Companion Policy Form.
7. You must review the payroll dates and the lag time in payment of the first payroll check. You should also review the probationary work period.
8. The criminal history record check that is provided by the Service Facilitator for each hired applicant. For MR Waiver individuals, if the applicant has been convicted of crimes as described in 12 VAC 30-90-180, the applicant will not be reimbursed for services provided to you. If you hire a personal assistant/companion and find out that the person has a conviction, fire him or her and look for another personal assistant/companion. The personal assistant/companion will be paid for the period of time the personal assistant/companion provided services to you. For MR Waiver individuals, a description of the crimes listed in 12 VAC 30-90-180 is provided on Page 35.

REMEMBER!! When you hire each new personal assistant/companion, you must request a hire packet from the program's fiscal agent. In addition to completing and submitting the information in the hire packet, the Employment Agreement Between the Personal Assistant/Companion and Employer, the Personal Assistant/Companion Competency Certification Form and the Personal Assistant/Companion Policy Form (in this manual) must be completed and submitted to the fiscal agent.

THESE FORMS ARE SENT TO THE FISCAL AGENT FOR EACH NEW PERSONAL ASSISTANT/COMPANION ONLY ONCE.

PERSONAL ASSISTANT/COMPANION CONTRACTUAL AGREEMENTS

A contract is defined as a binding agreement. A contract between you and your personal assistant/companion will help establish and maintain a successful working relationship. It will help to define the mutual responsibility that you and the personal assistant/companion share. Misunderstandings can and probably will arise between you and your personal assistant/companion from time to time. A written agreement to which to refer to can clarify many work-related disagreements.

When you hire your personal assistant/companion, you must have the personal assistant/companion sign the “Employment Agreement Between Employer and Personal Assistant/Companion” (Appendix D). A Copy of the contract should be given to the personal assistant/companion, and a copy must be given to the fiscal agent.

CRIMINAL HISTORY RECORD CHECK

The following is a description of crimes as described in the Code of Virginia that will apply to the Consumer-Directed Services Programs. If the personal assistant/companion is convicted of one of these crimes, the personal assistant/companion will not be reimbursed for services provided to you after the criminal history record check confirms the conviction. The list of crimes can be found in Section 8.1 of § 32.1-126.01 of the Code of Virginia and Chapter 994 of the Acts of Assembly of 1993 (Item 313.T).

Under the Consumer-Directed Personal Assistant/Companion Services Program, a individual shall not hire for compensated employment persons who have been convicted of:

1. Murder,
2. Abduction for immoral purposes as set out in § 18.2-48, Code of Virginia,
3. Assaults and bodily wounding as set out in Article 4 (§ 18.2-51 et seq.) of Chapter 4 of Title 18.2,
4. Arson as set out in Article I (§ 18.2-77 et seq.) of Chapter 5 of Title 18.2,
5. Pandering as set out in § 18.2-355,
6. Crimes against nature involving children as set out in § 18.2-361,
7. Taking indecent liberties with children as set out in § 18.2-370 or 18.2-370.1,
8. Abuse and neglect of children as set out in § 18.2-371.1,
9. Failure to secure medical attention for an injured child as set out in § 18.2-314,
10. Obscenity offenses as set out in § 18.2-374.1, or
11. Abuse or neglect of an incapacitated adult as set out in § 18.2-369.

The Service Facilitator will assist you with the completion of the Criminal History Record Check and will submit the Check on your behalf. Remember, you must submit one for every personal assistant/companion you hire for this program.

If you hire a person who has been convicted of a crime that is not listed in Section 8.1 of § 32.1-126.01 of the Code of Virginia and Chapter 994 of the Acts of Assembly of 1993(Item 313.T), and wish to continue employment with the person, you will need to complete the Consumer/Employment Acceptance of Responsibility For Employment Form in Appendix F.

RECORD KEEPING

As an employer, it is recommended that you establish some type of record keeping system. This system may be through the use of a spiral notebook or by using folders to maintain documentation regarding your personal assistant/companion. The documentation may include the personal assistant/companion's job application, the interview, copies of time sheets, the agreement between you and your personal assistant/companion, etc. If you keep good records you can avoid disagreements over payment of wages, and you will find it is easier to fill out any required reports.

PAYROLL REQUIREMENTS

As each personal assistant/companion is hired, he or she will be required to fill out an I-9 form for payroll purposes. This is required by the Federal government.

The completed and signed I-9 form must be sent to:

Department of Medical Assistance Services
MR Waiver CD Program
Fiscal Division
P.O. Box 662
Richmond, Virginia 23218-0662

This is to be done within three (3) days of hiring each personal assistant/companion.

A copy of the I-9 form and instructions on its use is in the following pages.

Personal assistant/companions will not be paid until the forms are submitted and processed.

EMPLOYMENT ELIGIBILITY VERIFICATION - FORM I-9

In November 1986, the Federal government began requiring all employers to verify the identity and work eligibility of their employees. The Federal government needs to be sure all employees are US Citizens or aliens authorized to work in the United States.

The government requires employers to have their employees fill out an I-9 form **within three days of hire**. This applies to all employees hired after November 6, 1986. Form I-9 has been developed to verify that people are eligible to work in the United States. Complete this form as follows:

1. When a personal assistant/companion is hired, he or she needs to fill out and sign the top portion of the form I-9 on their first day of employment (Appendix G). He or she must print or type his or her complete name, address, date of birth and Social Security number.
2. The prospective employee must show you two (2) of the listed documents, usually a valid driver's license and Social Security card, or birth certificate. (See list of appropriate documents on the next page).
3. After you have seen these documents, check off the appropriate boxes and sign the bottom. Send the original Form I-9 to:

Department of Medical Assistance Services
MR Waiver CD Program
Fiscal Division
P.O. Box 662
Richmond, Virginia 23218-0662

It is kept as a permanent record in each personal assistant/companion's file.

DETERMINING PERSONAL ASSISTANT/COMPANION COMPETENCY

You are required (as employer) by the Department of Medical Assistance Services to determine the Competency of the Personal Care Assistant/Companions.

You decide on the competency of your personal assistant/companion. This is based on the ability of the personal assistant/companion to meet your needs as identified in your written job description. **WITHIN 3 WEEKS FROM THE DATE OF HIRE**, you need to complete the Competency Certification Form (Appendix I) and forward the form to the Department of Medical Assistance Services. All personal assistant/companions must have a competency Certification Form on file.

The Department of Medical Assistance Services address is:

Department of Medical Assistance Services
MR Waiver CD Program
Fiscal Division
P.O. Box 662
Richmond, Virginia 23218-0662

TRAINING NEW PERSONAL ASSISTANT/COMPANIONS

The key element in training your personal assistant/companion is to provide clear, concise, organized direction.

When training your personal assistant/companion, be comfortable giving all the instructions yourself. In addition, you may find a checklist will help your new assistant/companion learn the routine. After you review the checklist, it should be posted. Use your job description to make sure all areas are covered. You may want to re-explain your disability as a refresher at this time.

When explaining procedures, include each step concisely and clearly. **DO NOT ASSUME THAT YOUR ASSISTANT/COMPANION UNDERSTANDS**; have him or her repeat it back and demonstrate where applicable. This will prevent much anxiety and avoid careless mistakes. Be sure to explain any potential health emergencies you may anticipate. You should document these conditions on paper to include any activity that the personal assistant/companion will have to perform in an emergency. Also, list your primary physician and telephone number, allergies, preferred hospital facility, disability, and rescue/fire department phone number. Always keep this listing in the same place near the phone.

Remember, training does not just occur the first day or week. Review frequently with your personal assistant/companion to assure that they are performing as you expect. It also keeps you skilled in giving directions.

SPLIT-SHIFT SERVICE DELIVERY

There are situations where you may benefit from personal assistant/companion services offered during two distinct shifts during the day (i.e., morning and evening shifts). The plan of care that you develop with your Service Facilitator should indicate each shift of services.. The total number of hours of morning and afternoon plans of care for the CD-Services cannot exceed the number allowed for your level of care without prior approval from The Department of Mental Health, Mental Retardation and Substance Abuse Services (“DMHMRSAS”). Inappropriate use of hours on split-shift service delivery may result in your removal from consumer-directed personal assistant/companion and/or respite services by DMHMRSAS. You are encouraged to contact your Service Facilitator when unusual situations occur.

**SAMPLE
PERSONAL ASSISTANT/COMPANION DUTIES CHECKLIST**

| | SATISFACTORY | NEEDS IMPROVEMENT |
|---|--------------|-------------------|
| A. PREPARATION | | |
| 1. Get clothes ready | | |
| 2. Prepare bath water | | |
| 3. Check bathroom temperature | | |
| 4. Make sure needed materials are available | | |
| 5. Ensure privacy | | |
| | | |
| B. ROUTINE | | |
| 1. Assist in clothing removal | | |
| 2. Move from bed to bath | | |
| 3. Wash and rinse hair | | |
| 4. Assist with hair care | | |
| 5. Move from bath to dressing area | | |
| 6. Dry body thoroughly | | |
| 7. Conduct skin check (check for pressure sores) | | |
| | | |
| 8. Apply lotion or powder | | |
| 9. Apply deodorant / makeup, or shave | | |
| 10. Assist in dressing | | |
| 11. Move to wheelchair | | |
| 12. Assist with dental care | | |
| 13. Move to breakfast area | | |
| | | |
| C. CLEAN-UP | | |
| 1. Put away all materials | | |
| 2. Clean bathroom | | |
| | | |

PERSONAL ASSISTANT/COMPANION JOB EVALUATIONS

Evaluating your personal assistant/companion is an important part to personal assistant/companion management and helps to insure their reliability and competency. The appraisal can also be used to identify areas of weakness in their job performance before they become major issues.

After you write your personal assistant/companion job description, use it to set up a checklist of the specific tasks that your personal assistant/companion must perform. This checklist will provide a tool for evaluating your personal assistant/companion's performance. It can also be used as a supplement to the job description for giving your prospective personal assistant/companion a more detailed look at each specific task that has to be learned.

The checklist will include all of the job duties that you expect the personal assistant/companion to perform. You can use the checklist to train new personal assistants/companions.

While the checklist outlines what needs to be done, it is still your responsibility during the training to provide feedback on how it is to be done.

The most important part of managing new personal assistant/companions is to give your personal assistant/companion feedback ~ both praise and constructive criticism. Using the checklist system gives you a chance to solve small problems before they become too big. Checklists can also serve as a responsibility contract that can protect both you and your personal assistant/companion by providing a permanent record of the job responsibilities. They are also helpful in providing documentation for a job reference of an ex-personal assistant/companion and can be useful should you need to justify firing a personal assistant/companion. On the following page you will find a sample checklist that will help you in designing your own.

COMMUNICATING WITH YOUR PERSONAL ASSISTANT/COMPANION AND CREATING A GOOD WORK ENVIRONMENT

It is a fact that personal assistant/companion work is usually not well paid and offers few, if any, fringe benefits. Therefore, those who take this kind of job often do it because it has other rewards, such as personal satisfaction or a chance to work closely with other people. That makes the work environment a most important factor in keeping your personal assistant/companion.

Good employers create a work environment that will bring out the best a personal assistant/companion has to offer. You will want your assistant/companion to have good morale, be happy and satisfied with his or her work and therefore, be a productive employee. Good communication between you and your personal assistant/companion can help do this.

To create that good work environment:

1. Reward personal assistant/companions for the work they are doing. Besides paying them, it is important to praise them frequently as well. Everyone wants to feel appreciated, needed and important.
2. When you criticize something your personal assistant/companion has or has not done, it is important to be open and honest and to criticize the action, not the person.
3. Don't let small irritations build up until an angry explosion occurs. Anger vented in these explosions often is expressed in a hurtful and destructive way. If you feel irritated about something that is happening, talk about it as soon as possible. This may happen daily, especially if you have just begun to work together.
4. Respect your personal assistant/companion. They are human beings and should be treated accordingly. Use the Golden Rule and treat your employee as you would like to be treated. Be honest, fair, kind, respectful and patient.
5. Personal assistant/companions have their own lives too. Although your personal assistant/companion has responsibilities to you, you should not attempt to control his or her life. Flexibility and compromise are important qualities for both of you.
6. Ask your personal assistant/companion how he or she feels about their work and about you as an employer. Set up a regular time to share feelings about your relationship. And then, both of you are open to making changes in the routine, in attitude or in anything else that can correct a problem. After all, this is your home where changes can and should be made.

To summarize, you as the employer have the opportunity to provide a positive work environment for your personal assistant/companion. This in turn helps him or her to be happy, productive and motivated to work for you. Good communication between the two of you is the key to this interdependent relationship. A personal assistant/companion who is happy in his or her work will stay with you longer and do a better job, which will benefit both of you.

RESOLVING CONFLICT

If you find you are having difficulty with your personal assistant/companion, make every effort to sit down and talk about the problem. In most cases, clearing the air and redefining your expectations will help.

In evaluating the job performance of your personal assistant/companion it is important to listen to your personal assistant/companion during the evaluation. Give your personal assistant/companion the opportunity to react to your feedback about his or her work performance. Give your personal assistant/companion your full attention. Show that you respect whom he or she is and what he or she is saying. Keep eye contact while talking with your personal assistant/companion. After your personal assistant/companion has finished speaking to you, rephrase what was said to make sure that you understand. Use statements such as “So what you are telling me is...” and “So you are saying...?” This gives you a chance to double-check and understand what your personal assistant/companion has said.

If a serious conflict arises between your personal assistant/companion and you, you may try to resolve the conflict rather than fire your personal assistant/companion. Sometimes even small issues can “mushroom” and become large issues if not resolved as they occur. When you confront your personal assistant/companion, be sure to define the problem or conflicts:

1. Describe the other person’s actions. Do not label, do not accuse, and do not insult him or her. Make sure the conflict is over actions, not personalities.
2. Define the conflict as a mutual problem that you want to solve, not as a win or lose struggle.
3. Define the conflict in the most specific way possible and give examples.
4. Describe your feelings and reactions to your personal assistant/companion’s job performance.
5. Describe how you may have contributed to the conflict.

After listening and talking together, try to agree on a solution that will resolve the conflict.

FIRING YOUR PERSONAL ASSISTANT/COMPANION

If you find that you are having difficulty with your personal assistant/companion, make every effort possible to sit down and talk about the problem. In most cases, clearing the air and redefining mutual expectations will correct the issue. If talking does not produce good results, it may be necessary to issue your personal assistant/companion a warning. Let him or her know that you are dissatisfied with their performance for the following reasons and give specifics. State that you expect to observe improvement within a specific time frame. If needed, write your concerns regarding job performance, give examples and give it to your personal assistant/companion.

If you still do not reach a resolution, fire the personal assistant/companion. As the employer, you have the right to fire your personal assistant/companion. You may need to dismiss your assistant/companion for excessive tardiness, absenteeism without notice, abuse or unauthorized use of your possessions. Be sure to tell the personal assistant/companion to return your house or apartment key and any other personal items prior to that person's last day of employment. Keep documentation that supports the reason why you fired your personal assistant/companion.

Try to give your personal assistant/companion some notice if the problem cannot be overcome. This allows you time to find a new personal assistant/companion and allows the personal assistant/companion to seek out other employment. **IN CASES OF ABUSE, FRAUD, OR NEGLIGENCE, IMMEDIATELY DISMISS THE PERSONAL ASSISTANT/COMPANION.**

It is important to ensure that dismissal is done properly. You may need to have your personal assistant/companion continue to work until you find a replacement. Immediate dismissal of a personal assistant/companion emphasizes your need for a backup system. When interviewing people for the personal assistant/companion position, specifically look for persons who, due to time conflicts, are unable to work on a permanent basis. These prospective personal assistant/companions are ideal for your backup list. If you feel it is appropriate, obtain a contract with terms of duties to be performed with each person that agrees to work as a backup assistant/companion. Make a list of these persons and their phone numbers and keep it in a convenient location.

Having a list of alternate personal assistants/companions allows you to fire a personal assistant/companion should the situation arise, without fear of being unable to find a replacement or having to inconvenience friends or family members.

INABILITY TO OBTAIN PERSONAL ASSISTANT/COMPANION SERVICES

If you are unable to find a backup personal assistant/companion you can request from the service facilitator a list of persons who are on the service facilitator's registry. You can use this list to find a new personal assistant/companion or receive temporary care until you find another personal assistant/companion.

If you are unable to consistently obtain or retain personal assistants/companions to provide services, the Department of Medical Assistance Services ("DMAS") will consider this a serious threat to your safety and health if you do not have a support system available to provide backup support. DMAS considers a high degree of continuity to be no more than three days missed coverage in a six-month period. If you are in the MRWaiver and the Service Facilitator determines that your health and safety are at risk because you are unable to consistently obtain or retain personal assistants/companions, the Service Facilitator will contact DMHMRSAS to transfer you to another provider that provides agency-directed Personal Assistance/Companion services.

You may decide that, because of the difficulty involved in hiring and retaining personal assistants/companions that you are no longer interested in receiving services under this program. You may leave this program at any time and make a request to your Service Facilitator that you wish to be screened to see if agency-directed services or another long-term care option is appropriate for you.

Please notify your Service Facilitator and the Fiscal Agent immediately if you are no longer interested in employing your own personal assistants/companions..

SAFETY AND PRECAUTION

It is important that you emphasize the safety of your personal assistant/companion at all times. You and your personal assistant/companion must take precautions when handling human body fluids, such as:

- Blood;
- Any body fluid that is visually contaminated with blood;
- Feces;
- Vomit;
- Saliva;
- Semen; and
- Vaginal secretions.

If there is a possibility that your personal assistant/companion will come into contact with blood or other potentially infectious materials, he or she should always wear protective gloves and coverings, such as aprons or eye goggles. Gloves are to be used when the personal assistant/companion is providing any personal care services that may come into contact with blood and other potentially infectious materials, non-intact skin, and mucous membranes (e.g., eyes). Your personal assistant/companion can become exposed or become contaminated when he or she is changing dressings and bathing people who have broken skin. Disposable gloves used during your care are not to be washed or decontaminated for re-use. They are to be replaced as soon as practical when they become contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is in question. Face masks or goggles are to be used when there is a possibility of splashing or spraying of blood or other contaminated materials onto your personal assistant/companion. For example: splashing could include a cut that is bleeding a lot, puddling or splashing on a firm surface, or a container of urine that is accidentally spilled or dropped on the floor.

In certain circumstances, protective clothing should be worn by the personal assistant/companion to protect against the contamination of personal clothing with blood or other potentially infectious materials.

After removal of personal protective gloves, your personal assistant/companion should wash his or her hands and any other potentially contaminated skin areas with soap and water immediately or as soon as possible. If your personal assistant/companion is exposed to broken skin or mucous membranes (e.g., around the eyes, mouth) then those areas should be washed or flushed with water as soon as possible following contact. If your personal assistant/companion is exposed and expresses concern, contact your local Department of Health as soon as possible.

You should also inform your personal assistant/companion that the Department of Health does Tuberculosis testing and offers Hepatitis B vaccines for a fee. You should encourage your personal assistant/companion to be tested for Tuberculosis and to be vaccinated against the Hepatitis B virus.

You should give this information to your personal assistant/companion while you are training him or her. It should be reinforced daily if your personal assistant/companion has trouble remembering to follow this important health practice. If your personal assistant/companion will be exposed to your blood or blood products, you can request gloves from a Durable Medical Equipment provider of your choice. Gloves are only available for this reason.

ACCIDENTS ON THE JOB

No one expects an injury to occur to your personal assistant/companion while he or she is working for you. However, the potential certainly exists.

As the employer of your personal assistant/companions, you are expected to be aware of any hazards in your home that could be a potential cause of an injury. You are also expected to provide clear, safe directions to your personal assistant/companion while they perform personal care or household tasks. PERSONAL ASSISTANT/COMPANION SAFETY is the number one priority while directing and managing personal assistants/companions.

If you are unaware of how to direct a task, for example a transfer, let your Service Facilitator know about your concern. They are available to assist you in developing a safe transfer technique through skills training. Other options include having an experienced personal assistant/companion work with you and your new employee demonstrating a transfer technique. Some individuals have elected to make a video tape of the transfer techniques and provide this as personal assistant/companion training. *Remember, it is much easier and less costly to prevent an injury than it is to treat one.*

If your personal assistant/companion is injured while under your employ, call the Service Facilitator **immediately**. Make sure your personal assistant/companion receives the appropriate attention.

| |
|--|
| <i>IMPORTANT: PERSONAL ASSISTANTS/COMPANIONS DO NOT RECEIVE WORKER'S COMPENSATION UNDER THIS PROGRAM AND ARE RESPONSIBLE FOR THEIR OWN MEDICAL BILLS.</i> |
|--|

UNEXPECTED DEATH AND YOUR PERSONAL ASSISTANT/COMPANION SYSTEM

What happens to your personal assistant/companion in the event of your death? This is a rather unpleasant topic, however, one that requires some of your thought and attention.

As a general rule, it is recommended that you have a plan of action written down and outline specific tasks that will need to be attended to in the event of your death. Likewise, we suggest that you share your ideas with someone dependable and trustworthy. Experience dictates that there is generally a high turnover rate for personal assistants/companions; therefore, you may consider asking a family member or close friend to oversee these matters.

Your personal assistant/companion time sheet needs to be submitted to the Department of Medical Assistance Services as usual. Personal assistants/companions will be paid up until the time of your death. As always, the payment will be directly sent to the personal assistant/companion.

COMPLETING PERSONAL ASSISTANT/COMPANION TIME SHEETS

Time sheets must be filled out completely and signed by you and your personal assistant/companion. Unsigned forms will be returned to you for signatures and no check will be issued to the personal assistant/companion until the time sheet is completed and returned. Time sheets cannot be signed electronically or faxed to the Fiscal Agent.

You will be responsible for paying the personal assistant/companion's wages with your monthly patient pay. The total wages of your personal assistant/companion will be listed on the time sheet, and you are to deduct your patient pay from this amount. The amount left unpaid by your patient pay will be paid by the Fiscal Agent. The Department of Medical Assistance Services WILL NOT reimburse your personal assistant/companion for the personal assistant/companion's wages that will be paid using your patient pay. For example, a personal assistant/companion worked two weeks and you owe him \$300.00. Your monthly patient pay is \$100.00. The \$100.00 will be subtracted on the time sheet and it will be your responsibility to pay your personal assistant/companion the \$100.00. The Fiscal Agent will reimburse the personal assistant/companion the remaining wages for that time period.

If you do not pay your personal assistant/companion the patient pay, you may be removed from the program.

A time sheet is required for each personal assistant/companion that you use. So, if you use two personal assistants/companions, then you will send in two time sheets. Send time sheets at the end of the pay period to:

Department of Medical Assistance Services
MR Waiver CD Program
Fiscal Division
P.O. Box 662
Richmond, Virginia 23218-0662

It is your responsibility to make sure that the Fiscal Agent receives the time sheet by the close of the pay period. The Fiscal Agent will process the time sheets and send the personal assistant/companion paychecks to the personal assistant/companion. **Do not send time sheets before the end of the pay period.** The Fiscal Agent will inform you of the pay schedule. Keep a copy of your timesheets. You will be billing for services that have been provided by your personal assistant/companion, so make sure you do not bill for more hours than you are eligible to use as specified in your Plan of Care.

APPENDICES

Appendix A

INDIVIDUAL SELECTION OF PERSONAL ASSISTANT/COMPANION SERVICES

I have selected _____ (hereafter referred to as “Facilitator”) as the approved Service Facilitator to coordinate my Consumer-Directed Services through the MR Waiver. The Facilitator has informed me regarding how much control I have over the personal assistants/companions who will provide my Personal Assistant/Companion Services. I understand that the MR Waiver will allow me to exercise my right to direct and supervise my own Personal Assistant/Companion Services in a manner that is consistent with my needs, capacity, and interests..

Individual As The Employer

1. Under the MR Waiver, I choose to employ the Personal Assistants/Companions who will provide my personal assistant/companion services. In selecting this service, I understand that I choose to be the legal employer of the Personal Assistant/Companions who will provide my Personal Assistant/Companion Services. As their employer, I have the right and responsibility to hire and direct them in the provision of my Personal Assistant/Companion Services and to perform and fulfill the duties of an employer, including recruiting, selecting, hiring, training, supervision, authorization and payment of wages, payment of taxes and insurance required, and dismissing assistant/companions, as necessary. I understand that I can also receive, at my request and as needed, assistance from the Facilitator in performing these tasks. I also understand that the Department of Medical Assistance Services will fulfill my payroll and fiscal duties and obligations as an employer by being appointed as my payroll and fiscal agent, to act on my behalf, by signing Internal Revenue Service (IRS) Form 2678 (“Employer Appointment of Agent”) and the MR Waiver Personal Assistant/Companion Services Program “Individual /Employer Appointment of Agent”
2. Once I select and hire a Personal Assistant/Companion I will notify the Facilitator. I will have the Personal Assistant/Companion sign a criminal history record check form, and the Agency will submit the form to the Virginia State Police on my behalf. If the Personal Assistant/Companion has been convicted of a crime as specified in 12 VAC 30-90-180, I agree to dismiss the Personal Assistant/Companion and search for another Personal Assistant/Companion.
3. I will establish the Personal Assistant’s/Companion’s schedule to provide services within the limits established in the Individual Plan of Care.
4. I understand that I have the primary responsibility for making arrangements for back-up Personal Assistant/Companions in the event a Personal Assistant/Companion is unable to work on a regularly scheduled work day. I agree to use family, friends, and neighbors as sources of back-up services where possible.
5. I am responsible for supervising the Personal Assistant’s/Companion’s record of hours worked. The Personal Assistant’s/Companion’s and my signatures on the time sheet attest that all times submitted for payment are actual and accurate. I understand that the MR Waiver Consumer-Directed Personal Assistant/Companion Services will only pay for Personal Assistant/Companion hours consistent with my Plan of Care.

My signature indicates that I have been informed of and accept my rights and responsibilities as an employer in the MR Waiver Consumer-Directed Personal Assistant/Companion Services.

Individual Signature _____ Date _____

Appendix B

SERVICE AGREEMENT BETWEEN THE INDIVIDUAL AND THE SERVICE FACILITATOR

This agreement is made between the _____ hereafter referred to as “Facilitator”, and _____, hereafter referred to as “Individual,” for the purposes of establishing the relationship, roles, and responsibilities of the parties. The Facilitator is a service facilitation provider enrolled in and authorized to provide services through the MR Waiver Program. The individual is eligible to receive the Personal Assistant/Companion Services.

A. Individual

1. By this agreement, the Individual chooses the Facilitator as the qualified provider of Service Facilitation Services that the Individual is authorized to receive through the MR Waiver Program. The Individual understands that the services that the Facilitator will provide are limited to those activities and tasks related to the individual’s approved Plan of Care.
2. The Individual agrees to follow the policies and procedures of the Facilitator, of the Facilitator’s designees, and of the MR Waiver Program, including:
 - a) Reporting to the Facilitator any changes that would affect the Individual’s eligibility or need for the personal assistant/companion services;
 - b) Receiving training and assistance from the Facilitator and participating in training for personal assistants/companions, as necessary, to ensure the Individual’s health and safety and the Individual’s continued participation in the Consumer-Directed services;
 - c) Allowing the Facilitator and/or representatives of the MR Waiver Consumer-Directed Services into the Individual’s home at least once per month to monitor the Individual’s participation in the personal assistant/companion services; and
 - d) Making available for the Facilitator’s inspection and copying documents and records required for the Individual’s continued participation in MR Waiver Consumer-Directed Services.

The Individual understands that failure to follow these policies and procedures may result in the Individual’s termination from the MR Waiver Consumer-Directed Personal Assistant/Companion Services.

3. The Individual understands his or her right to select personal assistants/companions, make decisions about, direct the provision of, and control the personal assistant/companion services to the maximum extent that the Individual desires and is capable. The Individual understands that he or she may request and receive assistance and support from the Facilitator in coordinating the Individual’s personal assistant/companion services.

SERVICE AGREEMENT BETWEEN THE INDIVIDUAL AND THE SERVICE FACILITATOR

4. The Individual is responsible for timely completion and delivery of personal assistant/companion time sheets according to the payroll schedule established by the Facilitator. The Individual understands that late arrival of time sheets may result in delay in the personal assistant/companions being paid.
5. The Individual agrees to pay through a Fiscal Agent the personal assistant/companion's wages in full on a regular schedule for the approved hours worked by the personal assistant/companion.
6. When a personal assistant/companion's employment ceases, the Individual agrees to notify the Facilitator of the date and reason the employment ceased.

B. Facilitator

1. As an authorized provider in the MR Waiver Consumer-Directed Personal Assistant/Companion Services and as the Service Facilitator selected by the Individual, the Facilitator agrees to provide service facilitation services.
2. The Facilitator will provide the following resources to the Individual as requested and/or needed by the Individual:
 - a) Training and skills development for the Individual and for the Individual's personal assistant/companions; and
 - b) A Personal Assistant/Companion Services Registry.
3. The Facilitator agrees to supervise the plan of care in a manner that ensures the Individual's health, safety, welfare, and personal autonomy, including periodic monitoring of the provision of the Personal Assistant/Companion Services. The Facilitator agrees to ensure that services provided to the Individual are authorized and appropriate.
4. The Facilitator agrees to maintain appropriate records and to provide the Individual with information necessary for the Individual's continued participation in the MR Waiver Consumer-Directed Personal Assistant/Companion Services.

C. Regulations

Any applicable federal, state, or local regulations pertaining to the provision and receipt of the Personal Assistant/Companion Services are hereby incorporated by reference in this agreement.

**SERVICE AGREEMENT BETWEEN THE INDIVIDUAL AND
THE SERVICE FACILITATOR**

D. Duration and Modification of Agreement

This written agreement constitutes the entire agreement and understanding between and among the Individual and the Facilitator. This agreement will be in effect as of the date the agreement is signed by the Individual and the Facilitator. The agreement can be modified by agreement of both parties. This agreement may be terminated immediately by either of the parties upon breach of any of its terms. This agreement may be terminated without cause upon ten-(10) days written notice of one party to the other.

Individual Signature _____ Date _____

Facilitator Signature _____ Date _____

Appendix C

INDIVIDUAL/EMPLOYER APPOINTMENT OF FISCAL AGENT

I, _____ (hereafter referred to as “Individual”), have chosen to hire and employ the personal assistant/companions who will provide Individual’s Personal Assistant/Companion Services through the MR Waiver Consumer-Directed Personal Assistance/Companion Services. The Individual elects to appoint the Department of Medical Assistance Services (hereafter referred to as “Fiscal Agent”) to assist in fulfilling the Individual’s duties and responsibilities as an employer of Personal Assistants/Companions. This appointment and authorization given to the Fiscal Agent is limited to those employees that the Individual employs as Personal Assistants/Companions through the MR Waiver. The Fiscal Agent will provide fiscal services to the Individual.

In signing Internal Revenue Service (IRS) Form 2678, “Employer Appointment of Agent,” the Individual appoints the Fiscal Agent to assist the Individual in preparing payroll for the Individual’s employee(s) and in fulfilling Individual’s federal tax obligations as an employer, pursuant to Section 3504 of the IRS Code. In signing the Virginia Personal Assistant/Companion Program “Individual/Employer Appointment of Agent,” the Individual elects and appoints Fiscal Agent as the Individual’s fiscal agent, to assist Individual in preparing payroll for the Individual’s employee(s) and in fulfilling all of the Individual’s other state and local obligations to pay taxes and unemployment compensation insurance, file forms, and perform any of Individual’s other obligations as an employer. In signing these forms, the Individual authorizes and directs the Fiscal Agent to do all that is required and necessary on the Individual’s behalf to comply with the provisions and requirements of federal, state, and local laws regarding the Individual’s registration as an employer.

In making this appointment, the Individual authorizes the Fiscal Agent to sign, on the Individual’s behalf, all payroll tax forms and other forms for which the Individual is responsible as an employer. Individual agrees to provide the Fiscal Agent with all necessary information and documentation required for Fiscal Agent to meet the Individual’s obligations in a timely manner in complying with all provisions of law and regulations which apply to employers. The Individual agrees to maintain all personnel records required by federal, state, and local laws in a permanent file for each Personal Assistant/Companion that the Individual employs. The Individual agrees to make available for inspection all personnel records pertaining to the employment of Personal Assistant/Companions and required for participation in the MR Waiver Program.

The Individual agrees to review and sign all Personal Assistant/Companion time sheets and submit time sheets to the Fiscal Agent. The time sheet will describe the number of hours a Personal Assistant/Companion worked and the total amount owed the Personal Assistant/Companion. The Individual will subtract his or her patient pay amount from the Personal Assistant/Companion’s gross earning on the first time sheet of every month and submit to the Fiscal Agent the adjusted gross amount due to the Personal Assistant/Companion. The Individual will pay the Personal Assistant/Companion the patient pay amount for services rendered. The Individual is responsible for paying the patient pay to the Personal Assistant/Companion.

This appointment is effective as of the date it is signed and accepted by both parties. Either party may terminate the agreement with ten-(10) days written notice to the other.

Our signatures indicate that the undersigned agree to the above.

Individual Signature _____ Date _____
Fiscal Agent Signature _____ Date _____

Appendix D
EMPLOYMENT AGREEMENT
BETWEEN EMPLOYER AND PERSONAL ASSISTANT/COMPANION

Parties to Agreement

This employment agreement is made this ____ day of _____, 20 ____, by and between _____, hereinafter called "Personal Assistant/Companion," and _____, hereinafter called "Employer." The purpose of this agreement is to establish the responsibilities of the parties to each other. The personal assistant/companion is an employee at will.

Compensation

The Personal Assistant/Companion shall be compensated for his or her services at the hourly rate of \$_____ Dollars.

Duration of Agreement

This agreement will be effective when it is signed by both parties. Either party may terminate this Agreement and the employment contemplated herein at any time and without liability for doing so, by giving the other party hereto at least 5 (five) days prior notice. Notice may be provided either orally or in writing.

Modification of Agreement

This agreement may be modified by agreement of both parties. Modification of this agreement must be in writing.

Scheduling

If the Personal Assistant/Companion is unable to work a scheduled time, the Personal Assistant/Companion shall provide at least _____ hours advance notice to the Employer, in order for the Employer to find an alternate. A change in time by the Employer or Personal Assistant/Companion must be scheduled at least _____ hours in advance. In case of emergency, the Personal Assistant/Companion will notify the Employer or another designated person. Such person shall be designated in advance, in writing. If a Personal Assistant/Companion is knowingly going to be late, he or she shall notify the Employer by telephone.

Personal Assistant/Companion Qualifications

The Personal Assistant/Companion attests that he or she meets the minimum qualifications for employment in the MR Waiver Program:

1. Personal Assistant/Companion is 18 years of age or older;
2. Personal Assistant/Companion has the required skills to perform assistant/companion care services as specified in the Employer's service plan;
3. Personal Assistant/Companion possesses basic math, reading, and writing skills;
4. Personal Assistant/Companion possesses a valid Social Security number;
5. Personal Assistant/Companion is willing to submit to a criminal record check;

6. Employer agrees to select or employ Personal Assistant/Companion **on an interim basis pending completion of a criminal history record check, for those crimes as specified in 12 VAC 30-90-180.** The Employer has discussed with the Personal Assistant/Companion and reserves the right to dismiss the Personal Assistant/Companion based on the results of the criminal history record check.
7. Personal Assistant/Companion can demonstrate the capability to perform health maintenance activities required by the Employer or specified in the Employer's service plan, or be willing to receive training in performance of the specified health maintenance activities.

Personal Assistant/Companion Duties

Duties of the Personal Assistant/Companion include, but are not limited to, the following:

1. Personal Assistant/Companion agrees to assist the Employer by providing the services and performing the activities specified in Employer's service plan.
2. Personal Assistant/Companion agrees to protect the health and welfare of the Employer by providing authorized services in accordance with the policies and standards of the MR Waiver Program, including the Minimum Qualifications for Employment as a Personal Assistant/Companion.
3. Personal Assistant/Companion agrees to provide Personal Assistant/Companion Services as specified in the Employer's service plan on a schedule mutually agreed upon between the Employer and the Personal Assistant/Companion. Occasional variations in the Personal Assistant/Companion tasks and in the schedule may occur, based on mutual agreement of the parties.
4. In the event of illness, emergency, or incident preventing Personal Assistant/Companion from providing scheduled service to the Employer, the Personal Assistant/Companion agrees to notify the Employer as soon as possible so that the Employer can obtain assistance from someone else.
5. Personal Assistant/Companion agrees to participate in training in providing personal assistant/companion services, including training in performing any health activities, as required by the Employer or as specified in the Employer's service plan.
6. Personal Assistant/Companion agrees to confidentially maintain all information regarding the Employer and to respect the Employer's privacy.
7. Personal Assistant/Companion agrees to pay all required federal, state, and/or local wage and/or income taxes levied against the Personal Assistant/Companion's wages. The Personal Assistant/Companion agrees to cooperate with the Employer and the Employer's Fiscal Agent in providing information needed to comply with all income and unemployment taxation laws and regulations.
8. Personal Assistant/Companion understands that this agreement does not guarantee employment or payment of wages for any time period.
9. Personal Assistant/Companion understands that the Personal Assistant/Companion is employed by the Employer and not by the Service Facilitator Provider, the Employer's Fiscal Agent, or the Commonwealth of Virginia.
10. Employer's property is not to be used for the Personal Assistant/Companion's personal use, unless mutually agreed upon by both parties prior to use of property. All private matters discussed during working times shall be kept confidential.
11. Personal Assistant/Companions are to be punctual, neatly dressed, and respectful of all family members. All instructions as to care shall be carried out carefully. The Employer's telephone may be used only with permission.

Employer Responsibilities

1. Employer agrees to orient, train, and direct the Personal Assistant/Companion in providing the personal assistant/companion services that are described and authorized by the Employer's service plan or that are requested by the Employer.
2. Employer agrees to establish a mutually agreeable schedule for the Personal Assistant/Companion's services, either orally or in writing.
3. Employer agrees to provide adequate notice of changes in the Personal Assistant/Companion's work schedule in the event of unforeseen circumstances or emergencies, but such notice cannot be guaranteed.
4. In consideration of Personal Assistant/Companion's satisfactory job performance, the Employer agrees to authorize completed Personal Assistant/Companion time sheets and to pay the Personal Assistant/Companion net wages on a regular and timely basis according to a predetermined payroll schedule. Net wages will include gross earnings calculated according to the Personal Assistant/Companion's pay rate minus payroll deductions for federal income taxes, employee's share of FICA, state income tax, and other deductions as appropriate.
5. Employer agrees to pay all unemployment taxes on behalf of the Personal Assistant/Companion.

Mutual Responsibilities

The parties agree to follow the policies and procedures of the Employer's Service Facilitator, of the Service Facilitator's Agency's designees, and of the MR Waiver Program. The Personal Assistant/Companion and Employer agree to hold harmless, release, and forever discharge the Department of Medical Assistance Services and the Service Facilitator from any claims and/or damages that might arise out of any action or omissions by the Personal Assistant/Companion or the Employer.

Employer Signature _____ Date _____

Personal Assistant/Companion Signature _____ Date _____

Appendix F

INDIVIDUAL/EMPLOYMENT ACCEPTANCE OF RESPONSIBILITY FOR EMPLOYMENT

As an employer, I have the right to choose to hire and employ a personal assistant/companion who I know has been convicted of a crime that is not specified in Section 8.1 of § 32.1-126.01 of the Code of Virginia and Chapter 944 of the Acts of Assembly of 1993 (Item 313 T.). These convictions are:

1. Murder;
2. Abduction for immoral purposes as set out in § 18.2-48, Code of Virginia;
3. Assaults and bodily wounding as set out in Article 4 (§ 18.2-51 et seq.) of Chapter 4 of Title § 18.2;
4. Arson as set out in Article I (§ 18.2-77 et seq.) of Chapter 5 of Title 18.2;
5. Pandering as set out in § 18.2-355;
6. Crimes against nature involving children as set out in § 18.2-361;
7. Taking indecent liberties with children as set out in § 18.2-370 or § 18.2-370.1;
8. Abuse and neglect of children as set out in § 18.2-371.1;
9. Failure to secure medical attention for an injured child as set out in § 18.2-314;
10. Obscenity offenses as set out in § 18.2-374.1; or
11. Abuse or neglect of an incapacitated adult as set out in § 18.2-369.

In doing so, I understand that this decision and the consequences thereof are my sole responsibility. In making any and all hiring decisions as an employer, I agree to hold harmless from any claims and responsibility The Department of Medical Assistance Services, the agency the I have chosen to provide me with Service Facilitation Services and the agent I have chosen as my Fiscal Agent.

Individual Signature _____ Date _____

Appendix H

POLICIES FOR PERSONAL ASSISTANT/COMPANIONS

The personal assistant/companion is hired and supervised directly by the Individual. The personal assistant/companion must comply with the following policies:

1. There is a probation period of 21 days from the date of hire. A Competency Certification Form must be submitted within the first 21 days of hire.
2. The relationship between the personal assistant/companion and the individual is professional **confidentiality is required.**
3. The Policies Form, an I-9 Form, and a Service Agreement between the Personal Assistant/Companion and Employer must be completed and sent to the Fiscal Agent **prior to receiving the first pay check.**
4. Any change of address or marital status of the personal assistant/companion, must be reported immediately and a new I-9 be sent to the Fiscal Agent.
5. Time sheets must be filled out and signed by both the individual and the personal assistant/companion(s). These time sheets can not exceed the allotted number of hours. Time sheets are due to the Fiscal Agent within five days from the end of the pay period; otherwise, the paycheck will be issued with the next payroll. Incorrect time sheets will be returned and no paycheck will be issued. Time sheets must be submitted by the individual in accordance with the Fiscal Agent pay schedule.
6. All paychecks are mailed directly to the personal assistant/companion's home or are sent by direct deposit.
7. The personal assistant/companion will not be paid for services not performed (for example, during such time as the individual is hospitalized).
8. It is recommended that the personal assistant/companion obtain Personal Liability Insurance.
10. The personal assistant/companion must fill out a criminal history record request form and sign it. This form will be submitted on behalf of the individual by the Service Facilitator. The Service Facilitator will provide the individual with the results of the request. Any personal assistant/companion who has been convicted of crimes as described in 12 VAC 30-90-180 will not receive reimbursement for services provided to the individual after a conviction as described in 12 VAC 30-90-180 has been verified through a criminal history record request.

I understand that payment of personal assistant/companion wages is from Federal and State funds. Any false statements or concealment will be prosecuted under applicable Federal and State laws.

I have read and understand the above policies:

Signature - Personal Assistant/Companion

Signature - Individual

Date

Appendix I

**PERSONAL ASSISTANT/COMPANION
COMPETENCY CERTIFICATION**

INDIVIDUAL'S NAME _____

ADDRESS _____

I CERTIFY THAT _____
(Personal Assistant/Companion's Name)

ADDRESS _____

SS# _____ has been employed as a Personal Assistant/Companion since
_____.
(Date of Hire)

This individual:

_____ **IS COMPETENT** to carry out personal care assistant/companion
duties as required and directed by me.

_____ **IS NOT COMPETENT** and was terminated on _____.

INDIVIDUAL'S SIGNATURE _____

DATE _____

Appendix K

NOTICE OF DISCONTINUED EMPLOYMENT

The purpose of this form is to provide notice of the end of an employment agreement between the Individual and the Personal Assistant/Companion. The form provides an opportunity for either or both parties to document the reason(s) for the termination of employment.

This form can be completed individually by the Individual or the Personal Assistant/Companion, or by both parties (the Individual and the Personal Assistant/Companion).

INDIVIDUAL/EMPLOYER

Name:

Address:

Phone:

ASSISTANT/COMPANION

Name:

Address:

Phone:

Date employment ended:

Briefly state below the reasons for ending the employment agreement between the two parties:

Individual Signature: _____ Date _____

Personal Assistant/Companion Signature: _____ Date _____

Please return this form to:

Department of Medical Assistance Services
MR Waiver CD Program
Fiscal Division
P.O. Box 662
Richmond, Virginia 23218-0662

Appendix L

CERTIFICATION OF SERVICES RENDERED

INDIVIDUAL-DIRECTED PERSONAL ASSISTANT/COMPANION SERVICES TIME SHEET

This is to certify that _____
has been employed for a total of _____ hours, as shown below, at
\$ _____ per hour, and is entitled to payment, therefore, in the amount of \$ _____.

| WEEK 1 | SUN. | MON. | TUES. | WED. | THURS. | FRI. | SAT. |
|---------------|-------------|-------------|--------------|-------------|---------------|-------------|-------------|
| DATE: | | | | | | | |
| IN: | | | | | | | |
| OUT: | | | | | | | |
| IN: | | | | | | | |
| OUT: | | | | | | | |
| TOTAL: | | | | | | | |

| WEEK 2 | SUN. | MON. | TUES. | WED. | THURS. | FRI. | SAT. |
|---------------|-------------|-------------|--------------|-------------|---------------|-------------|-------------|
| DATE: | | | | | | | |
| IN: | | | | | | | |
| OUT: | | | | | | | |
| IN: | | | | | | | |
| OUT: | | | | | | | |
| TOTAL: | | | | | | | |

WEEKDAY HOURS: Week 1 _____ Week 2 _____ Total Weekday Hours _____

WEEKEND HOURS: Week 1 _____ Week 2 _____ Total Weekend Hours _____

GROSS PAY TOTAL (Total Hours x Hourly Rate): _____

(MINUS) PATIENT PAY: _____

ADJUSTED GROSS PAY TOTAL: _____

My signature certifies that I provided a service on the dates listed above. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material facts may be prosecuted under applicable Federal and State laws. I also understand that, if applicable, I will receive as part of payment for my services the individual's patient pay amount.

Assistant/Companion Signature: _____ Date _____

My signature certifies that I received a service on the dates listed above. I understand that I must pay the personal assistant/companion my patient pay amount, which goes toward the cost of services provided. I understand I am responsible for ensuring the personal assistant/companion receives the patient pay amount, if applicable.

Individual/Employer Signature: _____ Date _____

Office Approval: _____ Date _____